WIN PROJECT
FACILITY SURVEY
2002

2ND ROUND
REPORT OF MAIN FINDINGS

WOMEN AND INFANT HEALTH (WIN) PROJECT

JSI

This report was made possible through support provided by USAID/Russia, under the terms of Contract No. HRN-1-00-98-0032-00 Delivery Order No. 803 and John Snow, Inc. (JSI).

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assistance of Natalia Kisseleva

The Women and Infant Health Project (WIN) is implemented by John Snow, Inc.
in close collaboration with the Ministry of Health of the Russian Federation with partners
EngenderHealth, Johns Hopkins University Center for Communication Programs,
and University Research Corporation.

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LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AVSC	Association for Voluntary and Safe Contraception
CDC	Centers for Disease Control and Prevention
FCMC	Family-Centered Maternal Care
FP	Family Planning
HIV	Human Immuno-deficiency Virus
IEC	Information, Education, Communication
ID	Identification
IUD	Intra-Uterine Device
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
SPSS	Statistical Package for the Social Sciences
STD	Sexually Transmitted Disease
TV	Television
USAID	United States Agency for International Development
VCIOM	Russian Center for Public Opinion and Market Research
WIN	Women and Infant Health Project
WHO	World Health Organization

ACKNOWLEDGEMENTS

The United States Agency for International Development (USAID) in Moscow provided funding for the survey through the WIN Project, implemented by John Snow, Inc. The success of this survey is due to the help of the entire Women and Infant Health Project (WIN Project) team, and especially to the WIN Project Resident Advisor, Natalia Vartapetova, and WIN Project Program Coordinator Natalia Kisseleva.

We especially wish to thank the members of the medical staff of each participating facility for giving of their time so generously, and also their clients, who contributed their own perspective to enhance our understanding of women's health care in Veliky Novgorod, Perm, and Berezniki. Our team could not have accomplished so much in such a short period of time without the able assistance of the field supervisors, Dr. Marina Chirskaya in Veliky Novgorod, Dr. Elena Eremeeva in Perm, and Dr. Nadezda Zinchenko in Berezniki. We are also very grateful for the care and dedication of the medical students and interns in these cities who carried out the interviews. The WIN Project is indebted to each of them.

We gratefully acknowledge the assistance provided by the All Russia Center for Public Opinion and Market Research (VCIOM) for their very competent and careful handling of data entry for the survey data files.

We are also indebted to Karin Lockwood, who competently and efficiently manipulated the complex data files and produced the tables, and Diane Holland, who contributed thoughtful text and edited this report.

EXECUTIVE SUMMARY

Background

The Women and Infant Health Project (WIN) is a USAID-funded project that aims to improve the effectiveness and 'family-friendliness' of maternal and infant health services by training women's health care providers in evidence-based medical practices. The ultimate aim is to institute evidence-based medical practices more widely to improve the effectiveness and 'family-friendliness' of maternal and infant health services delivered by the Russian health care system. A pre-intervention survey of provider practices and client experiences was conducted in participating facilities in early 2000 to inform training programs, measure indicators of project effectiveness, and stimulate policy change. From mid-December 2001 to early February 2002, a second survey of provider practices and client experiences was carried out in the same facilities using the same protocol.

The facility-based surveys are a component of the evaluation designed for the WIN Project, which is comprised of pre- and post-intervention household and facility surveys and a routine monitoring system to track key indicators within participating facilities. The evaluation is designed to assess the effectiveness and impact of the project established in participating facilities in the three cities, Veliky Novgorod, Perm and Berezniki.

The focus of WIN interventions is on maternal and newborn health and nutrition, including promotion of exclusive breast feeding, family planning services for postpartum and post-abortion clients, protection against domestic violence, essential care of the newborn, and family-centered maternity care as a component of antenatal, delivery and postpartum care.

The project interventions consist of clinical and counseling training for health providers at all levels, community-based and facility-based information, education and communication (IEC) strategies for both families and providers, and advocacy and policy promotion. The training aims to reduce unnecessary medical intervention during pre-natal, delivery and neonatal care, and to improve postnatal and post-abortion contraceptive counseling.

The WIN Project is funded by the United States Agency for International Development, and is implemented by John Snow, Inc. Collaborating partners include the Ministry of Health of the Russian Federation; Engender Health (formerly Association for Voluntary and Safe Contraception); the University Research Center Quality Assurance Project; Johns Hopkins University Center for Communication Programs; and the All-Russia Center for Public Opinion Research (VCIOM).

Survey Objectives

The follow-up survey of providers and clients in 20 participating health facilities in three Russian cities was conducted from mid-December 2001 to early February 2002, after the project interventions had been in place for two years. The aim of the second survey is to provide post-intervention data to measure changes in selected indicators of effectiveness and impact achieved by the project as compared to the baseline data gathered in 2000.

Methodology

The follow-up facility survey obtained quantitative data from 503 providers and 1538 clients in maternity hospitals, women's consultation centers and children's polyclinics in three Russian cities. Medical students and interns administered four survey instruments (one for providers, and three for clients) designed for the Russian health care context. A Russian survey coordinator trained (in most cases re-trained) the interviewers and their three field supervisors, who were senior public health administrators in the participating cities. Over the course of about four weeks (with holidays intervening), medical staff providing prenatal, abortion and delivery services, and neonatal or pediatric care were interviewed. The universe of physicians working in targeted facilities, a systematic random sample of midwives and infant nurses, and at least 300 women coming to these facilities for each type of service (delivery and postpartum care, prenatal care, and abortion services) were targeted for interview. All those interviewed were read a statement of purpose and provided the opportunity to decline the interview.

Client sample size was calculated using prevalence estimates for selected indicators and a one-tailed test with 80% power to detect expected changes. A Russian survey research organization was responsible for data entry, and data were analyzed using the SPSS statistical package by US-based researchers.

The analyses are based on aggregated reports of individual respondents and provide estimates reflecting knowledge and reported practices of the average provider and experiences of the average client in the entire network of participating facilities. No analyses were performed that would enable identification of individual providers or clients.

Results

A total of 554 providers were contacted for interview. Of these providers, 19 refused to be interviewed and 32 started but did not complete the interview. Completion rates were fairly similar for all cities, and ranged from a high of 94% of all providers in Veliky Novgorod to 89% in Perm and 86% in Berezniki. The total number of providers successfully interviewed was 503.

Four hundred and forty-six postpartum women completed interviews, almost all prior to discharge from the maternity where the birth took place. Five hundred and thirty-three antenatal clients and 559 abortion clients also completed interviews.

Quantitative measures of key program effectiveness indicators using both provider and client reports were calculated. Monitoring indicators include knowledge of exclusive breastfeeding, women ambulatory during labor, women delivering with support of a family member, postpartum contact between mother and newborn, and the percent of postpartum and post-abortion clients who receive family planning counseling prior to discharge.

Information obtained from providers also included prenatal prescribing practices, medication to induce labor and care during labor, and knowledge and postpartum practice of skin-to-skin contact and immediate breastfeeding. Both provider and client-based reports of post-abortion care and the content of contraceptive counseling (including LAM) prior to discharge were also measured.

Of women who had had more than one pregnancy (including the current one) more than 70% of postpartum women and three-quarters of antenatal and abortion clients had least one previous abortion. Of those repeat abortion clients, 17.5 % had terminated a pregnancy by abortion within

the previous calendar year almost identical to the 17% that had terminated a pregnancy within the previous calendar year in the baseline survey.

Information obtained from providers about 'usual practices' was sometimes inconsistent with client reports, but overall, the level of inconsistency was decreased in the follow-up survey relative to baseline levels. Almost twice as many antenatal clients reported discussing contraception with medical staff at the facility (42% as compared to 23% at baseline). Twice as many post-abortion (82% as compared to 41%) and postpartum clients (47% as compared to 19% at baseline) received family planning counseling prior to discharge. However, those reports compare with 85% of antenatal caregivers, 67% of delivery caregivers and 95% of abortion providers who reported that they discuss contraception with their clients.

Approximately 95% of delivery care providers reported offering 'rooming-in' to mothers, and 82% of mothers said their baby stayed with them day and night. Very few mothers reported that their babies were taken to the nursery for the first night (9%), a sharp decline from baseline levels (62%). Of mothers who did not have rooming-in, half as many as at baseline (45% as opposed to 87%) said they were never offered the option.

Large steps have been taken in terms of supporting exclusive breastfeeding. Women start out to breastfeed their babies; 98% of postpartum women reported that they were currently breastfeeding. Of those, only 9.9% said their baby was given something to drink from a bottle during the hospital stay, which is a significant decrease from the 70% of women at baseline who reported the same (and 7% did not know if the baby was fed something else). Eighty-four percent of postpartum women said they fed 'on demand' and 14% fed on a schedule (2% said they fed when the staff brought the baby). This trend is a reversal from baseline data where fewer women fed on demand (28%) and a larger proportion fed on schedule (67%).

Sixty-seven percent of antenatal clients and 88% of postpartum women can correctly define 'exclusive breastfeeding' (breast milk and nothing else except vitamins, minerals or medicine). According to the same definition, over 97% of delivery and neonatal caregivers tell their clients to breastfeed exclusively for a full six months, an increase from the 25% of delivery and neonatal caregivers that gave this advice at baseline. Furthermore, just 2% of all postpartum women said they were advised to supplement their breast milk with water, as opposed to the 46% of all postpartum women to whom this was recommended at baseline.

One of the characteristics of 'family-centered maternity care' is closer contact between mother and baby and more involvement by other family members in antenatal preparations for the birth, and support during labor and in the postpartum period. We found that in participating facilities, 68% of the women said that they had no close person supporting them at birth. While still substantial, this is a decrease from the 96% of women who said they had no close person supporting them at the birth at the baseline survey.

Other discrepancies between provider and client reports highlight issues of quality of care from a client perspective. For example, 87% of abortion providers said they explain the procedure to clients prior to performing an abortion, yet only 62% of clients reported receiving such information.

There has also been a decrease in use of non-evidence based practices. At the same time, discrepancies between provider and client report persist. For example, only 4% of providers said an enema was usual practice for all women (15% said only for some women), but 25% of postpartum women report having an enema. Two percent of providers said giving IV solution was

usual practice for all women (93% said only for some women), but 57% of postpartum women report having an IV solution during labor. Only one percent of providers said medicine to induce labor was usual practice for all women (98% said only for some women), but almost one third of postpartum women (30%) report that their labor was induced. Eighty two percent of providers said allowing women to sit up during labor was the usual practice for all women, and 14% of postpartum women report they were not allowed to sit up during their labor.

Conclusions

Quantitative data obtained using sound methodologies are essential for project evaluation. These data can also be used to attain project objectives by providing a firm basis for policy discussions. In this instance, baseline data was used to stimulate action by policy-makers to change long-entrenched but unproven or unnecessary practices. Changes in some practices are evident by subsequent comparison to data collected after the intervention was in place for some time

Several conclusions can be drawn from these data:

- Prevalence of repeat abortion by all types of clients remains virtually unchanged from baseline.
- Contraceptive counseling in all women's health services has improved markedly, more than doubling for all three types of clients from pre-intervention practice.
- Many more women (9 out of 10) are exclusively breastfeeding throughout their hospital stay. And, now more providers actually counsel women to breastfeed exclusively for the first 6 months.

Maternity hospitals have altered their practices to support women who want to breastfeed exclusively. A change has occurred in routine hospital practice regarding breastfeeding, and these changes are in line with WIN's training in breastfeeding counseling and support.

Our findings from the second round of facility surveys show that some practices affecting quality of care have changed in accordance with WIN training. At the same time, some practices that are not evidence based persist, and there continues to be room for improvement.

These and other findings can be used to continue discussion and action among facility staff and policy-makers, and to encourage staff about the steps that they have already taken.

1. INTRODUCTION

Background

This survey is a component of the evaluation designed for the Women and Infant Health Project (WIN), a USAID-funded project. The WIN Project is establishing training programs and IEC/counseling interventions in three Russian cities for providers of a range of women's and newborn health services and their clients. The project trains Russian obstetricians, gynecologists, neonatologists, pediatricians, midwives and infant nurses in evidence-based medical practices. The ultimate aim is to institute evidence-based medical practices more widely to improve the effectiveness and 'family-friendliness' of maternal and infant health services delivered by the Russian health care system.

The focus of WIN interventions is on maternal and newborn health and nutrition, including promotion of exclusive breast feeding, family planning services for postpartum and post-abortion clients, protection against domestic violence, essential care of the newborn, and family-centered maternity care as a component of antenatal, delivery and postpartum care.

The project interventions consist of clinical and counseling training for health providers at all levels, community-based and facility-based information, education and communication (IEC) strategies for both families and providers, and advocacy and policy promotion. The interventions are guided by the following principles:

- Use of evidence-based medicine to enhance clinical practice
- Use of quality assurance methods involving both providers and clients in provision of quality services
- Promotion of a client-oriented focus
- Continuity and consistency in client-provider communications and across service levels.

The training aims to reduce unnecessary medical intervention during pre-natal, delivery and neonatal care, and to improve postnatal and post-abortion contraceptive counseling. Another component of the project is production of appropriate health messages and materials to inform and educate the population in the three target cities, and for use in participating facilities. The ultimate aim is to institute evidence-based medical practices more widely to improve the effectiveness and 'family-friendliness' of maternal and infant health services delivered by the Russian health care system.

The WIN Project Evaluation Strategy

The WIN Project will be evaluated using a suite of methods: pre- and post-intervention household and facility surveys, and a routine monitoring system to track key indicators within participating facilities. The evaluation was designed to assess the effectiveness and impact of the project established in participating facilities in the three cities, Veliky Novgorod, Perm and Berezniki.

The evaluation component of the project uses data to:

- provide quantitative information on current practices and knowledge to 'fine-tune' training programs
- monitor progress during the project in order to adjust project activities as necessary
- measure change in selected indicators of effectiveness and impact achieved by the project
- provide a firm basis for policy discussions.

At the start of the project, two surveys were conducted: a household survey of populations in the three cities, and a facility survey, which interviewed providers and clients in all participating facilities in the three cities. A system to monitor key health and process indicators was also instituted in participating health facilities, and at the city and oblast level.

The pre-intervention survey of provider practices and client experiences was conducted in participating facilities in early 2000. From mid-December 2001 to early February 2002, a second facility-based survey was carried out in the same facilities, using the same protocol. This report describes the results of the second, follow-up, facility survey.

Objectives of the Survey

This survey of women's health care providers and clients in targeted facilities specifically aims to obtain follow-up information on provider practices that are the focus of project interventions and on client reports of their experiences and satisfaction with the care they receive. The purpose is to obtain post-intervention data to measure changes in selected indicators of effectiveness and impact achieved by the project. The data will also be used to provide quantitative information on current practices and knowledge, and for examining areas of strength and weakness in the uptake of key WIN interventions.

2. METHODOLOGY

Questionnaire Design

The facility survey questionnaires draw on instruments developed by the Population Council for situation analyses of family planning facilities in other parts of the world, and by the MEASURE Evaluation Project assessment of the quality of family planning and reproductive health services. The WIN Project survey instruments were designed by JSI's technical advisor for evaluation and finalized in consultation with WIN Project staff and project partners.

Four interview questionnaires were prepared: one for providers of covering all types of care (abortion, antenatal, delivery and postpartum and neonatal services); and one for each group of clients (abortion recipients, antenatal care attendees, and women recently delivered). Postpartum women were interviewed either just prior to discharge from a maternity ward or when they brought their newborns to children's polyclinics (up to several months postpartum).

Russian translations of the four questionnaires were pre-tested twice in non-participating facilities in a city near Moscow, as well as revised and translated into Russian (and back-translated) prior to their use in the baseline survey. For the follow-up round, a few adjustments were made to the baseline questionnaire to correct some problems that had arisen during the data entry phase.

Sample

To calculate sample size, we estimated the pre-intervention prevalence of key indicators, and a minimum expected change that we wanted to detect[1] at the end of the project. Resources dictated that the field work could be maintained for no longer than three weeks, which we estimated would allow for interviews with all selected medical providers (estimated at about 425), and a minimum of 300 women who had recently given birth. Three hundred postpartum women was the minimum feasible sample size we estimated would be sufficient to estimate change in several key indicators between the baseline and follow-up surveys.

The providers to be contacted were the universe of all physicians working in facilities participating in the project (see below) who provide antenatal, abortion, delivery and postpartum services, neonatal/pediatric care and family planning counseling. A complete list of all medical staff at participating facilities was obtained, along with the timing of their special clinics or days that they were in attendance at the hospital or clinic, in order to ensure that interviewers could be assigned to complete interviews with each staff member.

Midwives and nurses follow similar protocols for the care they provide and have less flexibility in their practices than physicians. A systematic random sample of hospital midwives and pediatric nurses providing these services was selected for interview from staff lists. The lists of midwives and nurses compiled for the follow-up survey were markedly larger than those used for selecting the sample at baseline. This was probably due to incomplete lists at baseline. Rather than increase the size of the provider sample, a sample of these personnel comparable in size to the baseline was taken, either every third (in Perm and V. Novgorod) or every fourth (in Berezniki) person on each list depending on the city and original sample size.

In all, 554 providers were selected for interview (all physicians and half the midwifery and pediatric nursing staff), and a total of 503 consented and completed interviews. Completion rates were fairly similar for all cities, and ranged from a high of 94% of all providers in Veliky Novgorod to 89% in Perm and 86% in Berezniki. Nineteen providers refused interviews and 32 started, but did not complete, the interview.

In addition, all female clients coming to each participating facility during the period of the survey for the same services were invited to participate (a 'take-all' sampling strategy during a fixed data collection period). The frequency of women attending abortion and antenatal services far exceeds the number of births in these cities. An estimate of the patient load for abortion and delivery (postpartum) patients was obtained from annual number of births and abortions per facility. As mentioned earlier, a total sample of about 300 women who had recently given birth (inpatients and women coming for postpartum or neonatal care after delivery) was sought. This number of respondents was deemed sufficient to provide reliable estimates of change in selected indicators (total across all 3 cities) between the pre- and post-intervention surveys.

During the time period of data collection, all women coming for antenatal, and abortion services at the target facilities who consented were also interviewed, with a minimum sample of 300 women coming for each type of service. The survey coordinator kept a running tally of completed interviews, and field supervisors in the three cities were instructed to stop all

[1] All calculations were based on 95% confidence limits (the probability that the observed change is due to chance is less than 5%), a one-tailed test with 80% power (the probability of observing a change of the expected magnitude when the 'true' change falls within the confidence limits).

interviews when the requisite sample of postpartum clients was reached. The final sample of clients thus obtained was 533 women coming for antenatal care, 559 abortion clients, and 446 postpartum women.

Field Implementation, Data Editing and Entry

Seventeen medical students and interns and three senior medical administrators were recruited in the three cities to assist with fieldwork. In Perm and Berezniki, these were the same field staff who participated in the baseline survey; in V. Novgorod, the same supervisor, but 5 new interviewers in addition to 3 who worked on the baseline survey, were trained. In early November, the local Russian survey coordinator, an experienced epidemiologist, visited Novgorod and Perm (field staff from Berezniki traveled to Perm) and conducted the training course. On this visit the survey coordinator also met with facility directors and city supervisors, assisted with coding and sampling for the provider survey, and assisted the local supervisor with scheduling initial interviews and logistics.

Prior to the baseline fieldwork, central survey staff estimated the expected number of births in each city during the three-week period, and informed the city supervisors of the approximate number of postpartum clients expected to be available for interview (in proportion to the birth rate in each city). This was estimated to be about 150 clients (50% of the total sample) in Perm, 90 clients (30%) in Veliky Novgorod, and 60 postpartum clients (20%) in Berezniki.

The actual proportions of postpartum clients interviewed in each city obtained in the follow-up survey came quite close to this approximation: 26.2% of all the postpartum interviews (of the total 446) were conducted in Veliky Novgorod, 52.7% in Perm and 21.1% in Berezniki.

One supervisor in each city, reporting daily to the survey coordinator in Moscow by telephone, assigned interviewers to providers and client locations, keeping track of interviews that were refused or were impossible to complete.

Central project staff sent a letter to each facility director, explaining the purpose of the survey and enlisting his or her cooperation. Facility directors were also asked to complete a facility data sheet that obtained baseline information on the number of abortions, antenatal clients, live births, and stillbirths, neonatal and maternal deaths for the previous calendar year, which included a break for the New Year holiday.

Interviews were conducted between 19 December 2001 and 7 February 2002. Interviewers were assigned specific times to cover client interviews in facilities and instructed to approach each client after she emerged from her visit with the provider, asking for her cooperation in answering ‘some questions about maternal and child health issues’. Interviewers were assigned a private area in which to conduct the interviews. They read a greeting, which briefly explained the purpose of the WIN Project and asked for each woman’s consent to ask questions about her experiences at the facility. The client’s name was not recorded on the questionnaire.

Interviewers were asked to record refusals as well as those who consented to participate. There were no refusals recorded among antenatal clients, five among abortion clients, and only two among postpartum women.

Codes were assigned to each facility and each provider, to enable the survey coordinator and field supervisors to track interviews completed and those providers who refused to participate. The key to these code numbers was retained in Moscow headquarters, and was unknown to the survey

analysts. In order to ensure that all providers selected for interview were approached, the supervisor checked off the provider ID number as the questionnaires were completed. Interviewers read a statement to each provider, requesting consent to the interview and assuring confidentiality.

The city supervisor scheduled provider interviews, assigning interviewers to specified individuals. While these appointments could not be anonymous, the survey-assigned provider code number was the only identification recorded on the questionnaire itself. Questionnaires were carefully guarded, and the interviewers instructed not to show them to anyone except their supervisor, who collected completed questionnaires each day, and stored them until they could be sent to Moscow headquarters.

After review by the field supervisor, completed questionnaires were shipped to Moscow headquarters, where WIN project staff coded open-ended questions and completed office editing. The edited questionnaires and coding key for open-ended questions were sent to the All-Russian Centre for Public Opinion and Market Research (VCIOM), where the data entry programs were written and the data entered into computer files. These files were produced in an English version ready for analysis with the SPSS statistical analysis package.

Analysis

All results are based on *reports* from either providers or clients – knowledge, attitudes and usual practices reported by providers, and experiences and satisfaction with services reported by abortion, antenatal and postpartum clients. Many providers may be aware of what the 'correct' practice ought to be, and answer accordingly, but perhaps contrary to their usual practices. However, it is possible to assess whether this knowledge is routinely translated into actual clinical *practice* by assessing the experience of the average client.

In contrast, many facility surveys rely not only on reported knowledge and practices, but also on an assessment of clinical practice by independent observers. Such observations of provider-client interactions are highly time-intensive and require that observers are themselves fully trained in the evidence-based practices and counseling skills that are the objects of interest. While observations of actual provider-client interactions would enrich our data, neither this resource base of knowledgeable providers nor the time to conduct such observations was available before the WIN Project training activities started. The survey organizers deemed it infeasible to attempt observations in the short time frame available to obtain baseline data. Instead, we compare client reports of their experiences in these facilities with the practices providers report.

Except in a few cases, the sample size precludes analysis at city or facility level. The analyses in the following chapters are based on aggregated reports of individual respondents and are expected to provide reliable estimates reflecting knowledge and reported practices of the average provider and experiences of the average client in the entire network of participating facilities. No analyses were performed that would enable identification of individual providers or clients.

3. CHARACTERISTICS OF THE STUDY GROUPS

Facilities

Providers and clients in the 20 participating facilities in Veliky Novgorod, Perm and Berezniki were interviewed. The distribution of facilities by city and by type of service is shown in Table 3.1.

Table 3.1 Number and distribution of participating facilities by city and service type

TYPE OF HEALTH FACILITY	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Maternity	2	2	1	6
Women's consultation	3	2	1	6
Children's polyclinic	3	2	1	5
Family Planning center	0	2	1	3
Total	**8**	**8**	**4**	**20**

Health Care Providers

A total of 554 providers were contacted for interview. Of these providers, 19 refused to be interviewed and 32 started but did not complete the interview. (Eleven refusals occurred in facilities in Veliky Novgorod, 5 refusals in Perm, and 3 refusals occurred in Berezniki; 24 interviews in Perm and 8 in Berezniki were incomplete.)

These refusals do not appear to bias the final sample. Completion rates for provider interviews ranged from a high of 94% of all provider interviews in Veliky Novgorod to 90% in Perm and 86% in Berezniki. Eighty-six percent of the sampled providers were women, and 79% of those who refused were women (see Table 3.2). Completion rates were fairly similar for all specialties, ranging from 88% of all pediatricians to 90% of obstetrician-gynecologists and 92% of neonatologists, midwives, and children's nurses.

The total number of providers successfully interviewed was 503. The comparison of providers characteristics by whether they completed or did not complete or refused interviews by their clinical specialty, city and type of facility are shown in Table 3.2.

Table 3.2 Comparison of providers successfully and unsuccessfully interviewed according to specialty, type of facility, city, and sex (Percent interviewed and refused)

DISTRIBUTION OF:	COMPLETED INTERVIEWS (%)	INCOMPLETED/REFUSED (%)
Specialty		
Obstetrician/Gynecologist	41.9	41.2
Neonatologist	7.0	5.9
Pediatrician	17.5	23.5
Midwife	15.3	11.8
Children's Nurse	9.9	7.8
Other	8.2	3.9
Missing	0.2	5.9
TOTAL	100.0	100.0
Facility Type		
Maternity	38.4	31.4
Hospital Gynecology Unit	12.3	9.8
Women's consultation	18.9	29.4
Children's polyclinic	24.5	21.6
Family Planning center	5.8	5.9
Other	0.2	0.0
Missing	0.0	2.0
TOTAL	100.0	100.0
City		
Veliky Novgorod	36.6	21.6
Perm	49.9	56.9
Berezniki	13.5	21.6
TOTAL	100.0	100.0
Sex		
Female	86.9	78.4
Male	7.8	2.0
Missing	5.4	19.6
TOTAL	100.0	100.0
Number of respondents	503	51

Service providers ranged in age from 19 years to more than 60 years of age (Table 3.3), and the average provider had worked at the facility for 13.5 years.

Table 3.3 Age distribution and training profile of providers

10 YEAR AGE GROUP	PERCENT (N=503)
20-29*	17.9
30-39	28.2
40-49	30.6
50-59	15.3
60+	6.0
Missing	2.0
YEARS SINCE LAST TRAINING	
<1	69.8
1-2	20.5
2+	9.1
Missing	0.6

*Includes one 19 year-old

Providers were asked about their recent experience of in-service training. About 70% of the providers reported attending some kind of training course during the preceding year, and only 9% had not received any training for more than 2 years (Table 3.3).

Table 3.4 Percent providing services by clinical specialty and type of service

Type of Provider	Provides Abortions or Related Services	Provides Neonatal Services	Provides Delivery or Postpartum Care	Provides Antenatal Care	Provides Contraceptive Counseling	Provides Breast-feeding Advice
Obstetrician/ Gynecologist	83.5	8.3	59.6	55.0	62.1	40.7
Neonatologist	0.0	16.6	1.6	0.4	1.9	8.4
Pediatrician	0.0	40.0	9.0	16.8	15.2	21.1
Midwife	4.7	9.3	21.6	14.3	11.0	15.0
Children's Nurse	0.0	23.4	4.3	8.6	4.2	12.2
Other	11.8	2.4	3.9	5.1	5.5	2.6
Total Percent	100	100	100	100	100	100
Number of Respondents	127	205	255	280	309	393
Percent* of providers(N=503)	25.2	40.8	50.7	55.7	61.4	78.1

* Row percentages do not add up to 100 because providers may offer more than one type of service

The distribution of medical staff by the type of services they provide is shown in Table 3.4. Sixty-one percent of the 503 providers of health care services to women (obstetrician/gynecologist) and their newborns reported that they also gave counseling about contraceptives in the 3 months prior to the survey. This is an increase from less than half of all providers giving contraceptive counseling at baseline. We look more closely at the composition of providers who do contraceptive counseling in Chapter7.

Client Profiles

The demographic characteristics of different types of clients for women's health care services are shown in Table 3.5. We can see that the sample of clients interviewed was distributed among the three cities in about the same proportions as we had anticipated when planning the survey (Table 3.5). About 27% of all clients were from Veliky Novgorod, just over half were from Perm, and about 20% of our client interviews were conducted in Berezniki, the smallest of the three cities. This mirrors quite closely the proportionate distribution of the sample based on birth rates and population in the three cities (see Chapter 2).

Antenatal clients were, on average, younger than postpartum and abortion clients. More abortion clients than the other client groups were older than 35 years. The age distribution of the three client samples is shown in Figure 3.2.

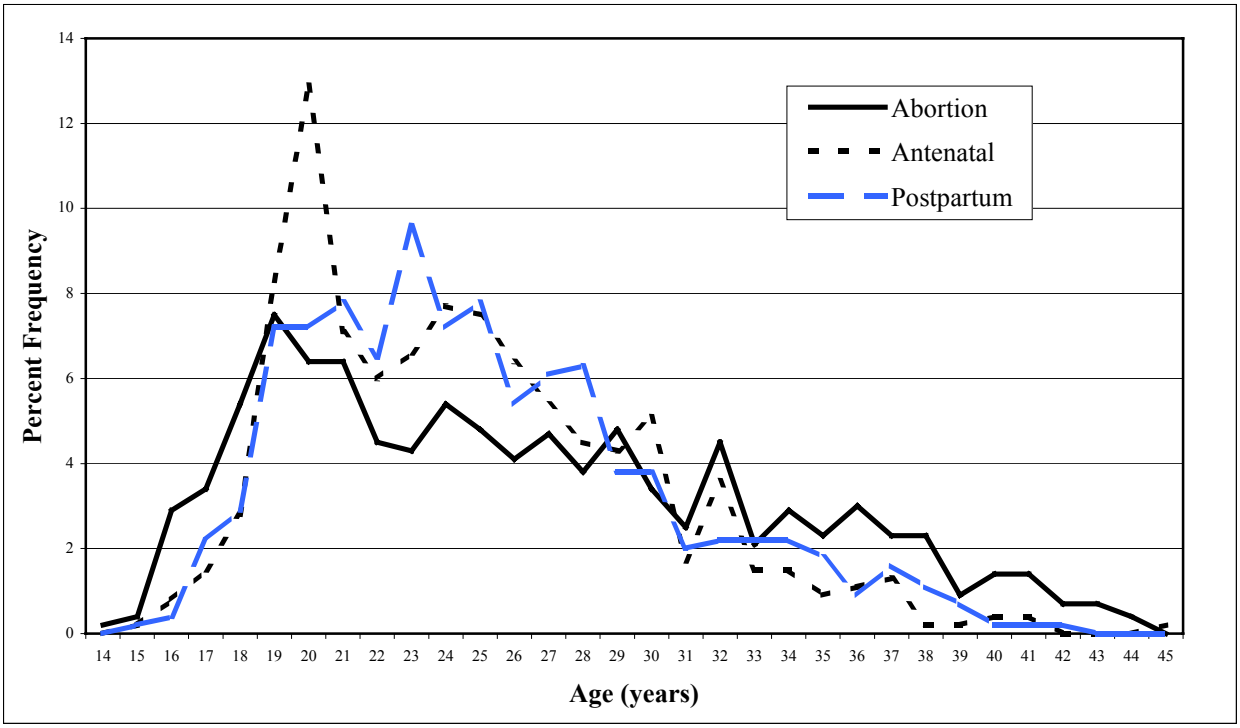
There was little difference in education among the different client types, but greater differences existed in their marital status. Not surprisingly, more abortion clients (28%) reported that they were not married (never married, or currently divorced, separated or widowed) than those coming for antenatal and delivery care (about 7%). Four times as many abortion clients as antenatal or postpartum women were single (never married).

Table 3.5 Demographic profile of clients

	Percent of Clients		
	Antenatal	Postpartum	Abortion
City			
Veliky Novgorod	26.8	26.2	28.3
Perm	50.1	52.7	49.6
Berezniki	23.1	21.1	22.2
Age Distribution			
15-24*	53.8	51.3	46.7
16-34	41.5	41.9	37.6
35-45**	4.7	6.7	15.7
Education			
Less than complete secondary	4.1	6.1	6.1
Completed secondary	33.8	35.9	41.0
Any higher post-secondary	62.1	58.1	51.1
Missing	0.0	0.0	1.8
Marital Status			
Married	60.2	67.5	45.6
In unregistered Marriage	33.2	25.6	25.8
Single, never married	5.6	6.5	23.6
Divorced/separated/widowed	0.9	0.4	5.0
Total Percent	100	100	100
Number of Respondents	533	446	559

* Includes one 14-year old abortion client. ** Includes one 49-year-old abortion client.

Figure 3.1 Age distribution of clients



Fertility history and intentions

Clients coming for all three types of services were asked a series of questions about their fertility history and plans for future births. The data shown in Table 3.6 show that clients for the different types of service vary with respect to their fertility history. Antenatal clients were over one and a half times (42% v. 26%) as likely to be in their first pregnancy as abortion clients. This is probably due in part to the fact that few women in these cities have more than two live births in their lifetime.

As we see in Figure 3.2 (data shown in Table 3.6), however, when we asked women about their abortion history, between 70 and 80% of clients (for each type of service) reported at least one abortion of a pregnancy prior to the current pregnancy (of women with second or higher order pregnancies). A surprisingly large proportion of abortion clients (59%) intends to have another child. These women appear to be using abortion as a means of controlling their fertility, not only to stop childbearing altogether, but also to delay the next birth. About one-quarter of antenatal clients, and a third of postpartum and abortion clients, report that they want no more children. Three times as many antenatal and postpartum clients as abortion clients report that they are undecided about wanting more children in future. Postpartum and antenatal clients report a desired wait of around four years (4.4 and 4.1) before the next child, while abortion clients report a slightly shorter wait (3.7 years).

Table 3.6 Fertility history and intentions

	Type of Client		
	Antenatal	Postpartum	Abortion
Mean number of pregnancies (including current)	2.21	2.39	3.48
Percent first pregnancies	42.4	38.6	25.8
Number of living children*			
0	70.2	0.0	35.6
1	25.0	68.4	39.5
2	4.5	26.9	22.7
3+	0.4	4.6	2.2
Number of respondents	533	446	559
Percent of women who have had (previous) abortions, of those with more than one pregnancy	75.2	71.9	80.0
Number of respondents	307	274	415
Of those, the number of previous abortions			
1	53.2	49.7	38.9
2	25.5	27.4	28.6
3+	21.3	22.9	32.4
Percent of women whose last abortion occurred within:			
Past one year	4.8	3.6	17.5
Past two years	26.8	27.4	41.0
Number of respondents	231	197	332
Intention to have another child**			
% yes	39.0	37.9	59.2
% want no more	25.7	30.7	31.8
% don't know	35.3	31.4	8.9
Mean desired length of time in years until next child, for those wanting another	4.1	4.4	3.7

* Including current birth for postpartum clients

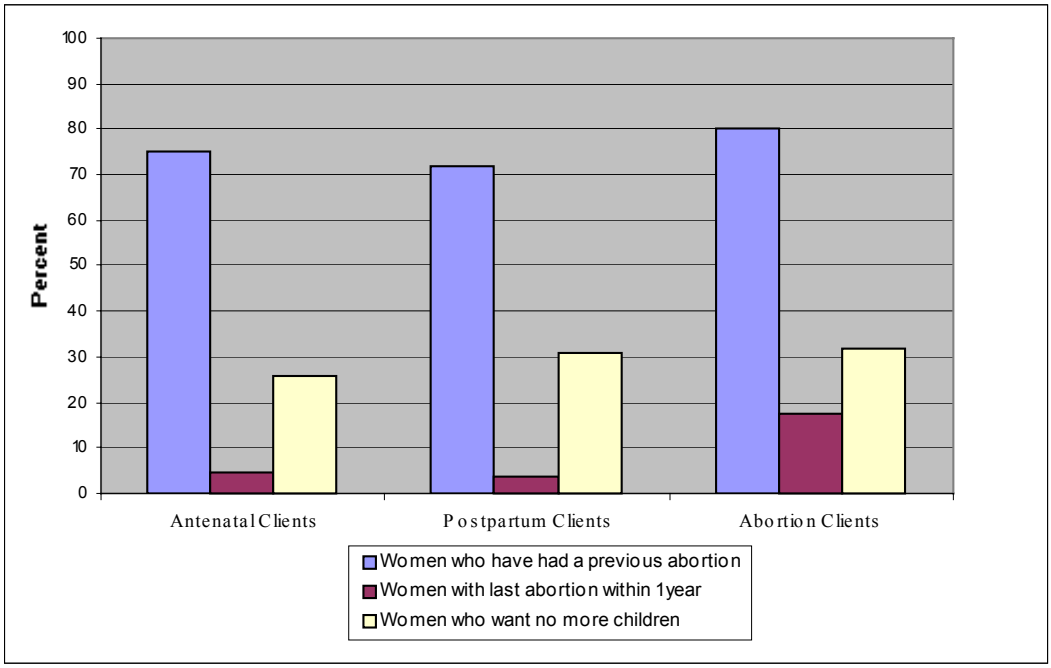
**Excludes antenatal and postpartum clients who report no regular partner

Repeat abortions
Seventeen percent of abortion clients in their second or higher-order pregnancy had terminated a pregnancy by abortion during the previous 12 months. On the other hand, only 5% of antenatal and 4% of postpartum clients who had terminated a previous pregnancy by abortion did so within the previous year.

Abortions following a birth
In addition, among those with living children, 7.8 percent of abortion clients (N=360) and 5.8% antenatal clients (N=104) had an abortion within one year of last live birth. At baseline, 8.4% of abortion clients (N=332) had an abortion within a year of last live birth.

Similarly, among those with living children, 14.4 percent of abortion clients (N=360) and 19.2% of antenatal clients (N=104) reported an abortion within two years of last live birth. At baseline, 16.3% abortion clients (N=332) reported that they had an abortion within two years of a live birth.

Figure 3.2 Client abortion history and fertility intentions



Contraceptive use among all clients

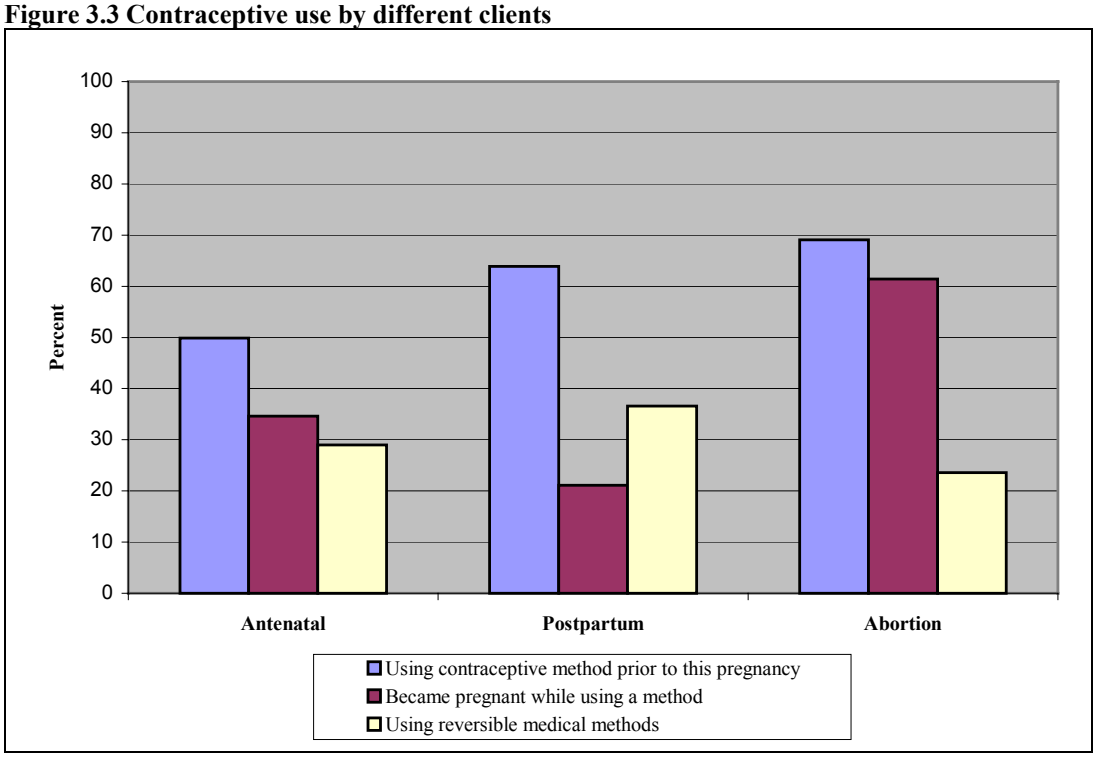
We also asked women if they had used a contraceptive method prior to their current pregnancy, and whether the pregnancy had occurred while using a method. The data in Figure 3.3 shows that antenatal clients were slightly less likely than postpartum or abortion clients to have used a contraceptive method. Fifty percent of antenatal clients were not using a method of contraception prior to their pregnancy, as compared to about 36 percent of postpartum clients and 31 percent of abortion clients who had not used a method (Table 3.7 panel A).

Of the abortion clients who were using contraception, only 24% were using the more effective medical methods – pills, IUD, injections or implants (Table 3.7 panel B). Over half were using a barrier method (condoms, spermicides, diaphragms or cervical caps), more dependent on correct

use, and nearly one quarter were using traditional – and much less effective – methods (withdrawal, 'natural' family planning – rhythm).

As we can also see from Table 3.7 (panel C), 65 % of antenatal and 79 % of postpartum clients were not actually using a contraceptive method when they became pregnant. It seems that many were actively trying to become pregnant. Abortion clients, on the other hand, often reported that they were using a contraceptive method when the pregnancy occurred (61%), indicating method or user failure.

Figure 3.3 Contraceptive use by different clients



Sixty percent of abortion clients who were using barrier methods became pregnant while using contraception. Between 75% and 95% of all clients (depending on the service they were attending) who became pregnant while using a method were using traditional methods of birth control (Table 3.7 panel D).

Table 3.7 Contraceptive use by clients

	TYPE OF CLIENT		
	ANTENATAL	POSTPARTUM	ABORTION
A. Use/no use of contraceptive method prior to this pregnancy			
% using	49.9	63.9	69.1
% not using	50.1	36.1	30.9
Number of respondents	533	446	559
B. Percent users by method type			
Medical	29.0	36.6	23.6
Barrier	48.8	49.8	53.4
Traditional	20.0	13.3	22.8
Other	2.3	0.4	0.3
Number of respondents	266	285	386
C. Percent who became pregnant while using a method			
% yes	34.6	21.1	61.4
% no	65.4	78.9	38.6
Number of respondents	266	285	386
D. Percent of users of each method type who became pregnant			
Medical	6.5	4.8	30.8
Barrier	33.9	20.4	60.2
Traditional	75.5	(68.4)	95.5
Other	*	*	*

*Estimates based on less than 25 cases omitted

( ) Estimates based on 25-49 cases

Note: Medical methods include pills, IUD, Depoprovera, and Emergency Contraception; barrier methods include condoms, spermicide/creams/jelly, diaphragm/cervical cap, and condoms + spermicide; traditional methods include LAM, withdrawal, and douching.

In each of the following chapters, we look at provider and client reports for the different types of health care: abortion services, delivery and postpartum care, and antenatal care. We look first at practices as reported by providers of these services who were actively giving care in the three months prior to the survey, and then at the experiences reported by their clients. We cannot match these client reports to the practices of specific providers. Rather, as noted earlier, these reports present us with a picture of the knowledge, attitudes and practices of the *average* provider and the knowledge and experiences of the *average* client across all of the participating facilities.

Key WIN Indicators

2nd round:

80% of abortion clients who had more than one pregnancy were repeat abortion clients

17.5% of repeat abortion clients terminated a pregnancy during the previous year

80.0% of contraceptive users (all clients combined) report using modern methods (medical or barrier methods) prior to this pregnancy

29.0% were using medical methods (oral, IUD, injections, implants, post-coital pill).

Baseline:

76% of abortion clients who had more than one pregnancy were repeat abortion clients.

17.1% of repeat abortion clients terminated a pregnancy during the previous year.

79% of contraceptive users (all clients combined) report using modern methods (medical or barrier methods) prior to this pregnancy.

32.5% were using medical methods (oral, IUD, injections, implants, post-coital pill).

4. ABORTION CARE

Provider Abortion Care Practices

One hundred and twenty seven providers in our sample reported providing either abortion services or counseling for abortion clients[2]. The distribution of providers by type of services provided is shown in Table 4.1. One provider designated as a midwife reports providing all types of abortion services, although midwives are not allowed to do abortions. This could be due to an interviewer error or an error that occurred during data entry. The analysis that follows, however, includes this individual. All those designated as midwives report that they provide counseling, as well as almost 90% of obstetrician-gynecologists.

Table 4.1 Type of abortion care provided

	TYPE OF PROVIDER		
SERVICE PROVIDED	OB-GYN DOCTOR (%)	MIDWIFE (%)	OTHER (%)
Mini-abortion*	33.0	(1)	(11)
Regular abortion	37.7	(1)	(12)
Late-term abortion	33.0	(1)	(5)
Counseling	88.6	100.0	(6)
Number of respondents	106	6	14

Columns do not add to 100% because providers could give more than one response.
Absolute number given in parentheses when number too small to calculate %.
* vacuum aspiration in the first six weeks of pregnancy
Note: One provider who provides abortion services is missing a specialty designation. Total providers of abortion care or related services, 127.

We asked providers of abortion services if they themselves tell abortion clients what will happen during the procedure, and if they explain what is happening while performing the procedure. Eighty-seven percent of providers report that they give clients information prior to the actual procedure, but only 40% say that they also explain what is happening during the procedure (Table 4.2). (As we will see when we look at client experiences, most abortions are performed under general anesthesia.)

Fifty seven percent of providers report giving pain medication when a patient experiences pain, and 77% report informing clients about self-care after the abortion. About half of these providers (52 %) themselves see patients for a post-abortion check-up. The remaining providers either refer clients to another provider at the same facility where the abortion is performed (9%), or refer their clients to another facility for a post-abortion check-up (29%).

[2] Only 127 providers said they gave abortion care during the previous 3 months, but 128 providers answered all remaining questions posed to abortion providers.

Table 4.2 Reported information given by abortion providers (N=128)

PROVIDER HIM/HERSELF GIVES:	YES (%)	NO (%)
Information to client before procedure	86.7	13.3
Information to client during procedure	39.8	60.2
Medication for pain	57.0	*39.1
Information to client about post-abortion self-care	77.3	**22.7
Sees patient for post-abortion check	51.6	
If no, refers to other provider at this facility	9.4	
If no, refers to other provider at other facility	28.9	
Not applicable	9.4	
Missing	0.8	

* 3.9% give medication to only some of their clients

** A few of these providers (0.6% of all abortion providers) say no one gives this information, one responded 'don't know,' and the rest say that someone else gives this information.

Post-abortion contraceptive counseling reported by providers

One objective of the WIN Project is to improve the immediate availability of post-abortion contraceptive methods and counseling in these facilities. Almost all providers of abortion care (almost 95%) report that they currently discuss post-abortion contraceptive methods with their clients, as the data in Table 4.3 show. The remaining providers say they refer their clients to someone else at the same facility to discuss post-abortion contraception.

Ninety-eight percent of these providers also say that they themselves inform the woman (either before or after the procedure) about when she can again become pregnant. The 'correct' answer to the question varies, depending upon the type of abortion a woman receives. For mini-abortions and others performed within the first trimester of pregnancy, a woman is at risk of pregnancy as early as two weeks following an abortion. For second trimester abortions, she can become pregnant again within 4 weeks. When asked when a woman can become pregnant post-abortion, more than two thirds (66%) of abortion providers in these facilities say "within 2 weeks", and one third gave an incorrect answer to this question (see Table 4.3). Two percent of these providers gave another answer (not coded), and some may have referred to these differences.

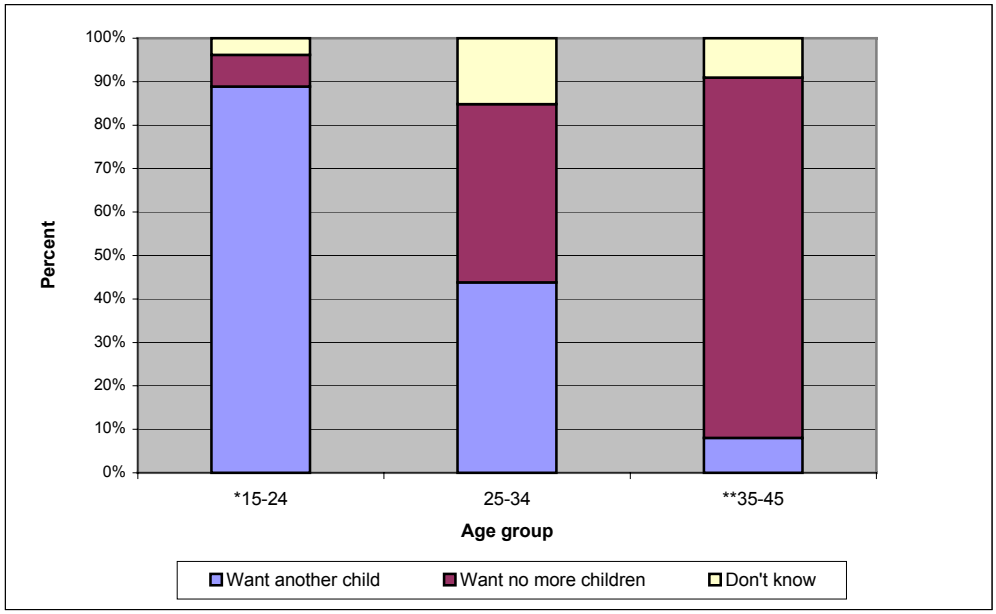
Table 4.3 Post-abortion counseling reported by providers

	PROVIDERS (%)
Talks about contraceptive method at time of procedure	94.5
Informs the woman of when she can again become pregnant	98.4
Reponses to the question, "When can a woman become pregnant again?"	
Within two weeks	66.4
Between 2-4 weeks	14.8
After menses returns or after one month	14.8
Other	2.3
Missing	1.6
Number of respondents	128

Abortion Client Experiences and Perceptions

First, we look more closely at the responses of abortion recipients regarding their fertility intentions. The data displayed in Figure 4.1 (and shown in Table 4.4) show that, while 59% of those who have just had an abortion plan to have a child at some future time, this varies markedly with the age of the client. Less than half of the women between ages 25 and 34 definitely intend to have a child in future (almost 44%) (the largest number of 'undecided' women are in this age group), and only 8% of women over age 35 intend to have another child.

Figure 4.1 Fertility desires of abortion clients by current age



* Includes one 14 year-old abortion client
** Includes one 49 year-old abortion client

Table 4.4 Abortion clients planning to have a child in the future by age group

	10-YEAR AGE GROUPS			
	*15-24 (%)	25-34 (%)	**35-45 (%)	TOTAL (%)
Yes	88.9	43.8	8.0	59.2
No	7.3	41.0	83.0	31.8
Don't know	3.8	15.2	9.1	8.9
Total	100	100	100	100
Number of respondents	261	210	88	559

* This group includes one 14 year-old
** This group contains one 49 year-old

In Chapter 3 we saw that almost 70% of abortion clients had used a contraceptive method prior to their pregnancy, and just over 60% of these women became pregnant while using a contraceptive method (a total of 237 women) (Table 3.7C). We now look at the specific types of contraceptives that abortion clients were using.

In the first column of Table 4.5 the distribution of all contraceptive users by type of method used is shown, and in the second column the distribution of users who became pregnant while using

each method. In the last column, the percent of all users of the general category of method who became pregnant while using that type of contraceptive method is given.

We can see from Table 4.5 that 30% of those relying on medical reversible methods became pregnant while using these methods. Although the numbers are quite small, we see that almost half of those women using oral contraceptives conceived while using them, suggesting that they were using oral contraceptives inconsistently.

Sixty percent of those who were relying on the less effective barrier methods became pregnant while using the method; nearly 55% of women using condoms and three-quarters of those using spermicides became pregnant.

Of the smaller number of women relying on traditional methods of contraception, nearly all (95%) of these users became pregnant while using such a method. Virtually all those who reported relying on the 'rhythm' method or withdrawal became pregnant while using the method.

Table 4.5 Distribution of last method used by whether pregnancy occurred while using the method

	% OF ALL USERS USING EACH METHOD	% OF USERS OF EACH METHOD WHO BECAME PREGNANT	% OF USERS OF METHOD TYPE WHO BECAME PREGNANT
Medical reversible	N=91	N=28	30.8
Pills	10.4	(45.0)	
IUD	9.6	(10.8)	
Injection	1.0	*	
Hormone/implants	0.3	*	
Post-coital pill	2.3	*	
Barrier	N=206	N=124	60.2
Condoms**	42.0	55.6	
Spermicide/creams/jelly	11.4	(75.0)	
Diaphragm/cervical cap	0.0		
Traditional	N=88	N=84	95.5
LAM	1.0	*	
Rhythm/withdrawal	21.8	(95.0)	
Other	0.3	*	
Total	100		61.4
Number of respondents	386		237

* Estimates based on less than 25 cases omitted

( ) Estimates based on 25-49 cases

** Includes clients who are using condoms and spermicides together.

Most abortion clients were using a contraceptive method prior to getting pregnant, but almost 31% (173 clients) were not using any method (see Table 3.7A). These clients were asked why they were not using a method of pregnancy prevention (Table 4.6). Most women could not or did not state a reason, but 5% said that the ease of obtaining an abortion was their reason, while almost 17% said that they had forgotten to use the method on that occasion. Five percent of these women, who had just obtained an abortion, said that they had wanted to get pregnant, but for some reason when the pregnancy occurred, these women decided to terminate it.

Table 4.6 Reasons for not using a method

	CLIENTS (%)
Wanted to get pregnant	5.2
Had method, forgot to use	16.8
Too expensive	2.9
Could not obtain any method	8.1
Abortion easy to obtain	5.2
Other	22.5
Don't know/unsure	39.3
Total	100
Number of respondents	173

We see from the data displayed in Table 4.7 that 72% of all abortions were conventional, induced abortions, and nearly 25% were mini-abortions (vacuum aspiration). Only 3% report having a late term abortion, that is, after twelve weeks of pregnancy.

Table 4.7 Distributions of abortions and reasons for obtaining abortion

	CLIENTS (%)
Type of abortion	
Mini-abortion	24.5
Regular abortion	72.3
Late-term abortion	3.2
Reasons for abortion	
Not a good time	24.9
Pregnancy dangerous to life/health	3.2
Risk of birth defect	3.9
Socioeconomic reasons	37.9
Do not have partner	1.8
Partner wanted abortion	3.4
Respondent did not want more children	19.9
Other	4.1
Don't know	0.9
Total	100
Number of respondents	559

More than 37% of abortion clients said they had the abortion for 'socioeconomic reasons' and almost 25% stating that the time was not 'right' to have a baby (Table 4.7). It is difficult to draw firm conclusions about the underlying motivations of these women from such general statements as these. Almost 20% of respondents replied that their reason for the abortion was that they did not want any more children.

Risk of birth defects or health reasons comprised another 4% of the reasons and 3% reported that their partner wanted the abortion. Some of the women who reported that they were not using contraception because they wanted to get pregnant may have obtained an abortion for these latter reasons.

Experience of abortion services

Women were asked what information they were given by medical staff, and how they were treated, before, during and after the procedure.

Table 4.8 Reports by abortion clients of experience of service provided

	PERCENT
Doctor gave information, prior to the procedure, about what would happen during the procedure	62.4
Doctor gave an opportunity to ask questions	88.7
During the procedure, client was:	
Awake	11.3
Half awake	2.1
Asleep	86.6
Of those women not asleep:	
Doctor explained what was happening during the procedure	
Yes	76.0
No	24.0
Woman wanted to know what was happening	
Yes	66.7
No	33.7
Woman was comforted during the procedure	
Yes	89.3
No	10.7
Woman was given medication to ease the pain	
Yes	84.0
No	16.0
Number of respondents	75
Of all respondents:	
Woman felt pain during the procedure	
Yes	7.9
No	92.1
Number of respondents	559

The reports of clients' experiences are displayed in Table 4.8. Almost 62% of abortion clients (three out of every five clients) reported that the doctor explained what would happen, but almost 12% said that they had no opportunity to ask the doctor questions before the procedure was carried out. This conflicts with reports by almost 87% of providers that they themselves give information about the procedure to clients prior to performing the abortion (see Table 4.2), suggesting that providers are inconsistent in providing such pre-procedure counseling.

The vast majority of clients, almost 87%, are asleep during the procedure. Since 25% of these clients received mini-abortions, this suggests that general anesthesia is used even for some of these simpler procedures (Table 4.7). In fact, more than 75% of the mini-abortion recipients reported that they were asleep during the procedure (data not shown).

Of those who were awake, most reported that someone comforted them during the procedure (89%). At the same time, 76% of these women reported that the doctor told them what was

happening as the abortion proceeded, and almost two-thirds of the respondents said they wanted to know. Sixteen percent these women were not given any pain medication.

We asked all women (awake and asleep) if they felt any pain during the procedure. Only 8% of the women reported feeling pain (Table 4.8), but 13 of these women said they felt pain despite being asleep during the procedure (data not shown).

Women were also asked about instructions for self-care following the abortion. Seventy-seven percent of providers said they themselves gave this information to abortion patients (Table 4.2). Almost 92% of clients report receiving such information, and 88% report that they received instructions about when to get a follow-up exam (Table 4.9).

Table 4.9 Information received by client about post-abortion care

	PERCENT
Told how to care for herself at home	
Yes	91.9
No	8.1
Told when to make a follow-up visit	
Yes	88.2
No	11.8
Number of respondents	559

Plans for post-abortion contraceptive use and contraceptive knowledge

All abortion clients were asked if they had been counseled about contraceptive use during their visit for the abortion, and there was a steep increase in the number of clients reported receiving such counseling, from about 40% to 82% of clients (Table 4.10). Most of those who did receive counseling appeared to be satisfied, more than 97% reporting that the information was given respectfully, and that their questions were encouraged.

The major drawback, it seems, is that partners were not participants in the counseling: three-quarters of all abortion clients wanted their partners to participate in this counseling, too. Only ten clients reported that their partner accompanied them and participated in a counseling session on the day of the abortion.

Table 4.10 Post-abortion contraceptive counseling

Medical staff talked about how to avoid another unplanned pregnancy (on day of abortion)	PERCENT
Yes	82.1
No	17.9
Number of respondents	559
Pregnancy prevention information given	
Respectfully	97.2
With indifference	2.6
Disrespectfully	0.2
Number of respondents	459
Questions encouraged	
Yes	96.7
No	3.3
Number of respondents	459
Client would like partner to participate in pregnancy prevention counseling*	
Yes	75.0
No	25.0
Number of respondents	517

* Excludes 10 women whose partners attended a counseling session that day and 32 women who report having no regular partner

As the data in Table 4.11 show, when asked what method of pregnancy prevention they will use about three-quarters of post-abortion clients say they have decided on a medical reversible method, and 99% name a modern method (medical reversible, sterilization or barrier method). However, 36% of abortion clients have not received professional advice about the method they have chosen, and almost 14% have not yet chosen a contraceptive method.

Table 4.11 Choice of contraceptive method for post-abortion clients

	PERCENT
Planning to use a method	83.5
Not yet chosen a method	14.1
Not planning to use a method	2.3
Number of respondents	559
Contraceptive method of choice (N=467)	
Oral contraceptives	34.0
IUD	36.4
Injections or implants	4.3
Condoms**	15.6
Spermicides, jelly, or creams	2.8
Post-coital pill (emergency contraception)	1.1
Tubal ligation	3.6
Natural family planning	0.4
Condoms and spermicides or other combinations	0.9
Other	0.9
Total	100
Discussed use of this method with (N=467):	
Medical staff	63.9
No one	36.1

** Includes clients who are using condoms and spermicides together.

Key WIN Indicators

2nd round:

17.5% of repeat abortion clients (gravidity 2 or more) had an abortion within the previous calendar year.

82% of post-abortion clients received or were offered family planning counseling on the day of the abortion at the facility where the abortion took place.

76% of abortion clients who know what method they will use post-abortion name a medical reversible method and 99% name a modern method—medical reversible, sterilization, or barrier.

64% of women discussed use of their chosen method with a member of facility medical staff.

Of these women, 88.7% said that the person had clearly explained how the method works, described the possible side effects, and explained what to do in case of problems with the method (an indicator of the quality of counseling provided).

Baseline:

17.1% of repeat abortion clients (gravidity 2 or more) had an abortion within the previous calendar year

41% of post-abortion women received or were offered family planning counseling on the day of the abortion at the facility where the abortion took place.

More than 75% of abortion clients who know what method they will use post-abortion name a medical reversible method and more than 90% name a modern method – medical reversible, sterilization or barrier.

48% of women discussed use of their chosen method with a member of facility medical staff.

Of these women, 89% said that the person had clearly explained how the method works, described the possible side effects, and explained what to do in case of problems with the method (an indicator of the quality of counseling provided).

5. ANTENATAL CARE

Since some of the WIN Project training focuses on evidence-based antenatal care, the follow-up survey sought to obtain a great deal of detailed information about changes in antenatal provider knowledge and practices. The WIN Project aims to ensure that all providers know which interventions have proven value and which may be unnecessary or even harmful to a pregnant woman and fetus.

Provider Antenatal Care Practices

Eighty-one providers who currently give care for antenatal clients in women's consultation centers were interviewed (Table 5.1). Most were obstetricians. We interviewed only providers at centers where routine antenatal care is provided. These are the antenatal caregivers with whom the project has worked, and we wanted to know about the kind of *routine* antenatal care given. The antenatal period is also the best time to start preparing women and their families for the experience of childbirth and to give information about infant care and feeding.

Table 5.1 Providers of ANC care in women's consultation by type of provider

	YES (%)
Obstetrician/Gynecologist	82.7
Midwife	16.0
Missing	1.2
Number of respondents	81

Almost all antenatal care providers report that they routinely perform tests for anemia and syphilis as well as routinely screen women for 'high risk' pregnancies (Table 5.2 panel A). All providers report routinely ordering ultrasounds for their clients.

Among the items providers report prescribing for their clients in the previous three months are some that are potentially unnecessary, or without proven value, such as vaginal creams (usually prescribed by 85% of antenatal care providers), herbs (80%) and homeopathic medicines (22%) (Figure 5.1). Some may even be harmful if prescribed inappropriately, such as hormones (8.8%) and antibiotics (33.8%).

Current World Health Organization (WHO) guidelines state that anemic women should receive and consume daily iron folate supplements for at least 90 consecutive days during pregnancy[3]. The WIN Project is following these guidelines. Others suggest that where anemia prevalence is high (more than 40% prevalence) women should continue the dose for 3 months postpartum[4]. Yet, of the almost 98% of antenatal caregivers who say they usually prescribe an iron preparation for pregnant women, only 60% prescribe it for as long as a month (Table 5.2 panel B). Only eight providers (10%) say they prescribe it for more than one month.

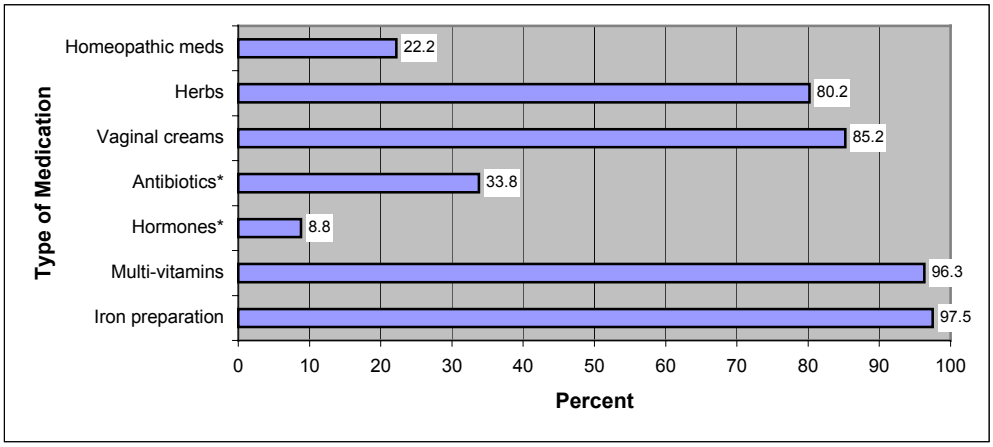
[3] World Health Organization Regional Office for Europe (1998) *Essential antenatal, perinatal and postpartum care.* Copenhagen: WHO Regional Office.
[4] Stoltzfus, RJ, Dreyfuss, M.L (1998), *Guidelines for the Use of Iron Supplements to Prevent and Treat Iron Deficiency Anemia,* cited in Elder, L. (2000) *Issues in Programming for Maternal Anemia,* Washington, DC: Mothercare.

Table 5.2 Antenatal care reported by providers

	YES (%)
A. Routine Care Practices	
Test for syphilis	100.0
Test for anemia	98.8
Screen for high risk pregnancies*	98.8
Order ultrasound procedure	100.0
B. Usual Prescribing Practices	
Iron Preparations	97.5
Of those prescribing iron (N=79), duration for which provided:	
Less than 4 weeks	21.5
One month	59.5
Other answers	19.0
Number of respondents	81

* N=80

Figure 5.1 Percent of antenatal care providers who usually prescribe various medications during pregnancy



*N=80

Many caregivers appear to select which clients need to hear about specific topics. Ninety-seven percent report that they discuss STDs and AIDS with their clients but only 22% say they ask about or examine women for signs of domestic abuse (Table 5.3). Evidence is now accumulating that domestic violence is a problem in these cities, as elsewhere in Russia[5]. Elsewhere, we report that between 17% and 24% of women of reproductive age have experienced threats or actual violent acts committed by a partner[6]. More than 75% of antenatal providers we questioned at this time say they do not ask any of their clients about domestic abuse or examine their clients for signs of injury.

[5] VCIOM, CDC, USAID *1999 Russia Women's Reproductive Health Survey: A follow-up of 3 sites, Preliminary Report: March 2000.*

[6] David, *et al*, (2000) *Women and Infant Health Project Household Survey 2000: Report of Main Findings*, Boston: John Snow, Inc., December.

Eighty five percent of antenatal caregivers say they discuss postpartum contraception with all their clients, and almost all report discussing with all clients warning signs of problems with a pregnancy, for which women should seek immediate medical attention (Table 5.3).

Table 5.3 Topics discussed with antenatal clients (N=81)

INFORMATION TOPICS	YES (%)	NO (%)
STDs, HIV or AIDS	97.5	2.5
Ask about/examine for domestic abuse	22.2	77.8
Postpartum contraception	85.2	14.8
Exclusive breastfeeding	98.8	1.2
Discuss warning signs for complications	98.8	1.2
Discuss warning signs for complications with partner/family*	33.8	66.2
Partner/family participation during childbirth	96.3	3.7
Option for rooming-in	96.3	3.7

* N=80

Only about a third of providers (34%) report that they discuss warning signs for complications of pregnancy with women's partners or other family members.

We also wanted to know which signs these providers mentioned when advising women when to seek immediate medical attention. There is general international agreement that women should be counseled to seek immediate medical care for the following danger signs that may occur during pregnancy:

- bleeding,
- acute abdominal pain,
- fever,
- premature rupture of membranes,
- headaches and/or blurred vision,
- swollen face or hands,
- vaginal discharge/itching or pain on urination, and
- reduced fetal movements.

While recommending women take action for other signs is not harmful, the providers who do counsel their clients about danger signs do not uniformly mention all of these, as the data in Table 5.4 indicate, and none of these signs were mentioned by all providers. Only 31% of all providers advise women to seek care for swollen face and hands (a warning sign for pre-eclampsia). Less than 15% mention vaginal itching or foul odor and only about 20% mention fever (possible infection).

Table 5.4 Signs for which women are advised to seek care

	YES (%)
Bleeding	96.3
Acute/constant abdominal pain	87.5
Headaches or blurred vision	80.0
Fever	21.3
Premature rupture of membranes	67.5
Premature labor	41.3
Burning with urination	6.3
Vaginal itching/foul odor*	13.9
Swollen face/hands	31.3
Swollen legs	38.8
Reduced fetal movements	62.5
Other*	12.7
Number of respondents	80

* N=79

Almost all antenatal care providers reported using a risk screening tool to classify pregnancies as normal or 'high risk' (99%). Women who receive a high-risk classification are often very restricted in their choices for delivery care (e.g. may not be allowed rooming-in or immediate breastfeeding or visitors). They may also be hospitalized for some period prior to delivery. In an open-ended question, we asked providers what were their usual reasons for labeling a pregnancy as high risk. We obtained a very long list of conditions. The ten most frequently cited reasons were coded and entered into the computer; the remainder was coded only as 'other'.

Providers (who could mention up to five different conditions) mentioned the conditions shown in Table 5.5 most frequently. Some of these diagnoses are not frequently encountered outside Russia, and require further explanation. 'Extra-genital pathology' refers to non-pregnancy related health problems, and was the most-frequently cited reason for classifying a pregnancy as 'high-risk'. However, most responses did not fall into the pre-coded categories.

Table 5.5 Reasons for classifying a pregnancy as high risk*

REASON MENTIONED	YES (%)
Extra-genital pathology	60.5
Renal diseases	2.5
Anemia	6.2
Albuminuria	0.0
STDs	6.2
High arterial pressure	8.6
Adiposity	1.2
Smoking	1.2
Bad nutrition	0.0
Other	93.8
Total number of respondents	81

* Percentages do not add up to 100 because providers could give more than one answer

Breast-feeding knowledge and advice

Another focus of the WIN Project training for providers (as well as IEC messages for clients) was breast-feeding advice, and the advantages and practice of exclusive breastfeeding. We asked antenatal caregivers to list what they recommended their clients to feed babies for their first six months. All providers responded to this question, and 94% of antenatal caregivers gave answers that are in keeping with the definition of 'exclusive breastfeeding' – giving only breast milk and nothing else (except vitamins or mineral supplements) for the first six months.

We also asked these providers when a mother should begin to give her baby anything in addition to breast milk, another way of asking what they recommend to their clients with respect to exclusive breastfeeding. Fifty-eight percent of providers responded 'at 6 months' and an additional 31% said '7 months'.

We asked what these providers usually recommend to their antenatal clients when discussing preparations for delivery and in the postpartum period. The data in Table 5.6 show almost all providers say they recommend clients to breastfeed their babies 'on demand' and only about 12% recommend a set schedule for breastfeeding. Eleven percent responded that they recommend breastfeeding on demand AND scheduled breastfeeds, suggesting that these terms are not yet fully understood by respondents. Almost all providers (95%), say they recommend that the baby should stay in the mother's room at all times ('rooming-in'), rather than in a nursery.

All providers report recommending that a woman participate in her own care, but this response provides a great deal of room for individual interpretation, and does not necessarily reflect the WIN Project's own definition of 'participation':

> Participation is a woman making informed decisions and choices regarding aspects of care related to her pregnancy, her well being and the well being of her fetus. Her active participation and that of her family is enabled and enhanced when a provider … places the woman and family at the center of care and collaborates with a woman and her family in designing a plan of care to meet their specific needs and preferences.

Almost all providers say they recommend that women and their partners have some type of joint preparation for the childbirth experience. Almost all of the providers (95%) say they recommend to their clients to have a family member present during the birth.

Table 5.6 Usual recommendations to antenatal clients

	YES (%)
Rooming-in	95.1
Breastfeeding on demand	98.8
Scheduled breastfeeds*	12.5
Partner or family member present at birth	95.1
Woman's participation in her own care	100.0
Childbirth preparation together (woman and partner)	95.1
Total number of respondents	81

* N=80

Key WIN Indicator

Percent of providers who can correctly define 'exclusive breastfeeding'

Proxy Indicators:

2nd round:

99% of providers say they discuss exclusive breastfeeding with their antenatal clients.

94% of providers say they recommend 'exclusive breast feeding' (giving breast milk and nothing else except vitamins, mineral supplements or medicine) for the first six months.

Baseline:

74 % of providers say they discuss exclusive breastfeeding with their antenatal clients.

47 % say they recommend giving only breast milk and nothing else (except vitamin and mineral supplements or medicine) for the first 6 months.

Antenatal client experiences and perceptions

Interviews were conducted with a total of 533 antenatal clients, most of whom (82%) began their visits for antenatal care in the first trimester of pregnancy (Table 5.7). Timing of first visit varied slightly by city of residence: slightly fewer women in Berezniki began their care in the first trimester (80%), while 88% in Veliky Novgorod and 79% in Perm began their care in the first trimester (data not shown). Few women waited until their third trimester to seek care (12 women in Perm, 1 in Berezniki, and none in Veliky Novgorod.)

As we see in Table 5.7, most of our respondents are currently in their third trimester of pregnancy. Because women come for care much more frequently in the third trimester (usually weekly), on any given day our interviewers were more likely to encounter a woman in her 3rd trimester than one who was in an earlier stage of her pregnancy. Most of our respondents have nearly completed their antenatal care.

Table 5.7 Trimester of first and current antenatal visit

	CLIENTS (%)
Trimester of first antenatal visit	
First	81.8
Second	15.8
Third	2.4
Number of respondents	532
Trimester of pregnancy of current visit	
First	2.1
Second	13.8
Third	84.2
Number of respondents	530

NOTE: First trimester = 1 week up to and including 12 weeks, second trimester = 13 weeks up to and including 24 weeks, and third trimester = 25 weeks and above.

Contraceptive use and fertility intentions

Before we examine women's reports of the antenatal care they receive, we look more closely at the women who reported becoming pregnant while using a contraceptive method. As we saw in Chapter 3, approximately half of antenatal clients reported that they were using a contraceptive method before they became pregnant (Table 3.7). Of former users almost one third (34%) became pregnant while actually using the method. Table 5.8 displays more detailed information about the methods these women were using at the time pregnancy occurred.

Apart from the lower proportion of users who became pregnant while using a method, there were a few noticeable differences in choice of methods between antenatal clients and abortion clients (compare with Table 4.5). Like abortion clients, nearly half of antenatal clients had been using barrier methods of birth control. However, only 34% of users of barrier methods were actually using the method when the pregnancy occurred. In contrast, more than 70% of the small number of antenatal clients using traditional methods conceived while using the method.

Table 5.8 Distribution of last method used by whether pregnancy occurred while using the method

	% OF ALL USERS USING EACH METHOD	% OF USERS OF EACH METHOD WHO BECAME PREGNANT	% OF USERS OF METHOD TYPE WHO BECAME PREGNANT
Medical reversible	N=77	N=5	6.5
Pills	18.4	6.1	
IUD	10.2	(7.4)	
Injection	0.0	0.0	
Post-coital pill	0.4	*	
Barrier	N=130	N=44	33.8
Condoms**	41.7	33.3	
Spermicide/creams/jelly	7.1	36.8	
Diaphragm/cervical cap	0.0		
Traditional	N=59	N=43	72.9
LAM	0.0	0.0	
Douching	9.8	(69.2)	
Rhythm method	10.2	(81.5)	
Other	2.3	*	
Total	100		34.6
Number of respondents	266		92

* Estimates based on less than 25 cases omitted

( ) Estimates based on 25-49 cases

** Includes clients who are using condoms and spermicides together.

Those clients who said they had not used a method before the pregnancy occurred were asked their reasons for non-use (Table 5.9). Most women wanted to get pregnant (82%), while about twelve percent said they were unsure of their reason for not using contraception.

Table 5.9 Reasons for not using a method

	CLIENTS (%)
Wanted to get pregnant	82.4
Had method, forgot to use	1.9
Too expensive	0.0
Could not obtain any method	0.4
Abortion easy to obtain	0.7
Other	2.2
Don't know/unsure	12.4
Total	100
Number of respondents	267

Antenatal clients were also asked how long they wanted to wait between the birth of this child and the next child. The data in Table 5.10 show the distribution of responses by age of the woman. Few women of any age – only 17% of the total – want to wait for three years or less between births, quite similar to the baseline findings. Only 18% of women under 35 and none of the older women want to have another child within 3 years. Thirty two percent of the youngest women said they want to wait more than 3 years before their next birth. And 10% of these young women want no more children; 40% of women 25-34 also want no more children. These responses clearly highlight the continued need for contraceptive counseling for women during the period leading up to their birth.

Table 5.10 Future pregnancy intentions by age group

	10-YEAR AGE GROUPS			
	15-24	**25-34**	**35-45**	**ALL AGES**
Wait three years or less	17.6	18.0	0.0	17.0
Wait more than three years	32.4	10.9	0.0	22.0
Want no more children	10.4	39.8	79.2	25.7
Don't know	39.6	31.3	20.8	35.3
Total	100	100	100	100
Number of respondents*	278	211	24	513

*Excludes 20 clients who report having no regular partner

Care received in the antenatal period

Antenatal clients were asked to report in some detail what care they had received during this pregnancy, including procedures they were subjected to, and medications they were instructed to take.

Ultrasound technology is used more frequently in Russia than in some other countries. The data in Table 5.11 show that 94 % of clients were given at least one ultrasound during the antenatal period. The second panel of Table 5.11 shows the distribution of numbers of ultrasound procedures women experienced by the current stage of their pregnancies. Women who are in the first trimester of pregnancy are exposed for less time to the chance of multiple ultrasound procedures. By the third trimester, almost 78% of women had 2 or more ultrasound procedures, and 29% were given 3 or more ultrasounds.

Table 5.11 Ultrasound procedures experienced by antenatal clients

			CLIENTS (%)
Ultrasound this pregnancy			94.4
Number of respondents			533
Distribution of ultrasounds by trimester of pregnancy	**1st**	**2nd**	**3rd**
0	*	27.4	0.2
1	*	43.8	21.7
2		23.2	49.6
3+		5.5	28.5
Number of respondents**	11	73	446
Told reason for ultrasound			83.7
Number of respondents			503
Distribution of reasons for ultrasounds* **			
Status of fetal development			52.3
Examination for the term of gestation			23.8
Examination for fetal developmental defects			21.1
Risk of loss of a pregnancy			7.4
Examination for fetal position			5.5
Examination for excessive amniotic fluid			1.2
Examination for placental localization			5.7
Determination of the number of fetuses			0.7
Checking if the umbilical cord is winding			0.2
Other			18.1
Number of respondents			421

( ) Estimates based on 25-49 cases

* Estimates based on less than 25 cases

** Excludes 3 clients who report not knowing how many months pregnant they are.

*** Percentages add up to more that 100% because more than one reason may have been reported.

Along with the frequency of these procedures, most antenatal clients (84%) reported that they were told the reason for an ultrasound procedure. The distribution of those reasons is shown in the bottom panel of Table 5.11. These data suggest that many procedures are carried out to assess fetal development, and may be done repeatedly. Fifty-two percent of women who were given a reason for the procedure said the reason they were given was to assess fetal development.

More than 80% (four out of every five women) were given a prescription for some kind of medication during their pregnancy. Seventy-nine percent said they had received a prescription for multi-vitamins (Table 5.12). Less than half of all antenatal clients (45%) reported getting a prescription for an iron preparation. However, more than half of antenatal clients reported receiving prescriptions for other medications. Ninety-two percent of women who received a prescription for any medication reported actually taking all of the prescribed medications. A similar proportion of respondents who were given a prescription (97%) was told the reason for the medications.

Table 5.12 Experience of services provided

	YES (%)
Given any prescription for medication during this pregnancy	82.9
Given iron preparation	44.5
Given multi-vitamins	78.8
Given others	54.0
Number of respondents	533
Told reason for that medication	96.6
Took the medication	91.9
Number of respondents	442
Received information on:	
STDs, HIV, AIDS	41.1
Alcohol and cigarettes	69.4
Drugs	50.1
Nutrition during pregnancy	91.0
Physical and emotional changes during pregnancy	66.8
Partner/family participation support during childbirth	70.4
Option to have baby with her day and night	66.0
Any of these topics discussed with partner/family members	23.5
Number of respondents	533

We asked antenatal clients what topics the medical staff had discussed with them on any of their antenatal visits. The data displayed in the second panel of Table 5.12 show that nutrition during pregnancy is the topic most likely to be discussed by providers (91% of women report receiving information about nutrition), followed by partner or family participation and support during birth (70%), alcohol use and smoking (69%), and changes expected during the pregnancy (67%).

In the previous section, we saw that almost all providers said they discussed STDs, HIV and AIDS with pregnant clients (Table 5.3), but only 41% of women report receiving information about that subject (Table 5.12). While discrepant, this is still a big increase from the baseline of 17%. Considering the importance of smoking during pregnancy, drug use, and risks associated with sexually transmitted diseases, these appear to be neglected topics for discussion with pregnant women.

Partner support during childbirth and the option to have 'rooming-in' with baby were discussed with more than two thirds of pregnant women, compared with provider reports that almost 95% discussed partner support at birth and 66% discussed 'rooming-in' (Table 5.6.). Only about a quarter (24%) of women report that any of these topics were discussed with her partner or another family member either individually or in childbirth preparation classes.

Of course, none of these women had completed their antenatal care, but 84% were in their 3rd trimester. These subjects should be discussed early enough in the pregnancy to allow women to make changes in their behavior, or to arrange for someone to be present – and learn how to support them – at their delivery.

Explanation of danger signs – women's reports

An important part of good antenatal care is ensuring that the woman understands the signs that indicate serious complications, for which she should seek immediate medical attention. Eighty-four percent of these antenatal clients reported hearing such information. This is consistent with

information reported by providers; almost all (98.8%) providers report telling all their clients about warning signs (Table 5.3). More women remember the doctor mentioning bleeding or spotting (84.7%) and abdominal pain (86.5%) than any other signs.

Only 13.9% of clients reported that the doctor also gave information on any danger signs to the client's partner or her family. This small proportion is inconsistent with reports from providers; 33.8% of providers said that they discussed the warning signs with families (Table 5.3). There is a need to further encourage the incorporation of family members in the process.

Table 5.13 Explanation of danger signs

	CLIENTS (%)
Doctor discussed danger signs requiring immediate medical attention	84.8
Number of respondents	533
Signs doctor mentioned to client	
Bleeding or spotting	84.7
Headaches or blurred vision	19.9
Abdominal pain	86.5
Fever	6.4
Premature rupture of membranes	44.0
Premature labor	33.0
Vaginal itching or foul odor	4.9
Swollen face or hands	14.4
Reduced fetal movements	41.6
Other	6.6
Number of respondents	452
Doctor gave this information to client's partner/family	13.9
Number of respondents	533

Antenatal clients were asked if they would like to have a close person present for support during labor and birth. As the data in Table 5.14 show, many women are now less reluctant (after the WIN intervention) to have anyone other than medical staff present during their labor and delivery.

Fifty-eight percent of antenatal clients would like their partner present, and 33% of women say they want no one else with them. This reflects a major change from antenatal client attitudes at baseline, when only 38% said they wanted a close person with them during labor, and 53% said they wanted no one.

Table 5.14 Percent of women wanting various persons for support during childbirth

	AGE GROUP			
	15-24 (%)	25-34 (%)	35-45 (%)	TOTAL (%)
Baby's father	50.5	49.8	(44.0)	49.9
Other family member	5.9	5.4	0.0	5.4
Female friend	0.7	0.5	0.0	0.6
No one	31.4	33.0	(48.0)	32.8
Don't know	11.5	11.3	(8.0)	11.3
Number of respondents	287	221	25	533

( ) Estimates based on 25-49 cases.

Preparation for the postpartum period

Antenatal clients were asked if anyone had discussed exclusive breastfeeding, care of the newborn or self-care after the birth during antenatal visits (Table 5.15a). More than two thirds (70.7%) of women reported discussing exclusive breastfeeding, almost half (48.2%) discussed care of the newborn, and more than one third (38.8%) had heard postpartum self-care discussed. (Almost all (98.8%) antenatal care providers say they discuss exclusive breastfeeding with their clients.)

Those clients who had discussed exclusive breastfeeding with their provider during antenatal care varied considerably by city (data not shown). Almost 87% of clients in Perm and 84% in Berezniki had been told about this at some time during their antenatal care, compared with only 39% of clients in Veliky Novgorod.

Table 5.15a Topics clients reported being told about in antenatal visits

INFORMATION TOPIC	YES (%)
Exclusive breastfeeding	70.7
Care of your newborn	48.2
Care of yourself after delivery	38.8
Number of respondents	533

The consistency between provider and client reports suggests that women get the 'message' when they receive it. Sixty-seven percent of all antenatal clients were able to correctly define the term 'exclusive breastfeeding' (giving breast milk and nothing else except vitamins, minerals, or medicine). This knowledge varied somewhat by city of residence: less than half (45.5%) of antenatal clients in Veliky Novgorod gave the 'correct' definition, but 71.9% of women in Perm and 80.5% in Berezniki were able to describe the internationally accepted definition. Discrepancies between what antenatal clients report and what their caregivers report are shown in Figure 5.2.

Almost sixty percent of women said that a baby should not be given anything in addition to breast milk until 6 months of age, while about 20% responded with an earlier age and 12% said they did not know (See Table 5.15b).

Figure 5.2 Reported counseling about breastfeeding during antenatal care

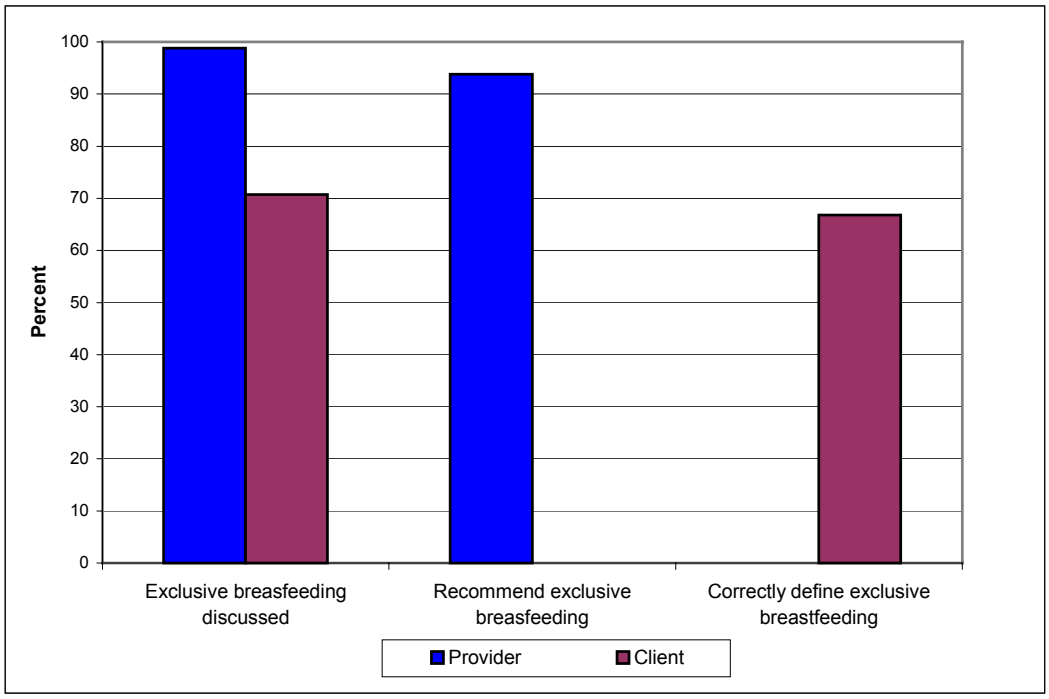


Table 5.15b When a child should be given other liquids or foods in addition to breast milk?

AGE OF CHILD	CLIENTS (%)
At five months or less	20.6
At six months	56.8
At more than six months	4.9
Don't know	12.4
Number of respondents	533

Almost all clients report that they are planning to breastfeed their baby (99%). Only 1% (n=3) had been advised not to breastfeed, and a similar number had been instructed how to use infant formula for feeding.

It is important for the project to identify those providers most likely to be consulted about breastfeeding to provide them with training so they are knowledgeable about current recommendations, and can therefore relay this advice to women. We asked antenatal clients who was the best person to consult if they had questions about breastfeeding, or needed advice. More than 60% of women said the best person to consult is a neonatologist or pediatrician (Table 5.16). A further 21% said an obstetrician was the best source of advice, followed by only 7% who thought a family member was best.

Table 5.16 Antenatal clients opinions on sources of breast feeding advice

BEST PERSON TO CONSULT ABOUT BREASTFEEDING	CLIENTS (%)
Obstetrician	21.0
Neonatologist/pediatrician	61.5
Midwife	1.7
Nurse	2.1
Friend	0.9
Family member	6.8
Breastfeeding support group	3.8
Other	1.1
Don't know	1.1
Number of respondents	533

Contraceptive knowledge and plans for contraceptive use

Another aim of the WIN Project is to increase the number of women who are aware of and use the lactational amenorrhea method (LAM) of contraception in the early postpartum period. LAM is an effective and safe method of contraception for the first 6 months of infancy if the mother exclusively breast-feeds on demand (day and night), and if her menses have not returned. The data in Table 5.17 show that only about one third of women (34.5%) believe that exclusive breastfeeding can be used as a contraceptive method, and only ten of those who did could correctly list all of the conditions under which it is effective. Just over forty percent of women (225 in all) reported that a provider had discussed the LAM method with them, 62% of antenatal clients in Perm, 38% in Berezniki, and only 9% in Novgorod.

Table 5.17 Women's beliefs about breastfeeding as contraception

	CLIENTS (%)
Think breastfeeding can be used as contraception	
Yes	34.5
No	26.8
Don't know	38.6
Of those responding yes (N=184),	
know all three correct conditions when it is effective	6.5
LAM was discussed with client	42.4
Number of respondents	533

Women were also asked what method of contraception they were planning to use after the birth. Of the more than 78% who planned to use a method, almost half (49%) named a medical reversible method of birth control (pills, IUD, injection/implant, post-coital pill). One hundred and seven antenatal clients said that they were planning to use LAM (26% of those planning to use any method), an enormous increase from the 2% who said at baseline that they would use LAM.

Table 5.18a Postpartum Contraception

	CLIENTS (%)
Planning to use a contraceptive postpartum	78.2
Number of respondents	533
Distribution of Methods	
Medical	48.9
Barriers	14.1
LAM	25.7
Rhythm or withdrawal	0.7
Sterilization	2.2
Other	8.4
Number of respondents	417

Few of these women said they planned to start using the method immediately (13.9%, excluding those who said that they chose to use LAM) (Table 5.18b). Although timing depends upon which method a woman chooses, many are not sure when to begin using, or will delay use until they have a postpartum check-up, which means they may be at risk of conception before they begin to use contraception. Women who plan to breastfeed also need to discuss appropriate contraceptive methods (that do not harm the infant or interfere with breast milk production).

Table 5.18b Plans for postpartum contraception by type of method and start timeframe

	TYPE OF METHOD					
	MEDICAL (%)	BARRIER (%)	WITHDRAWAL/ RHYTHM (%)	STERILIZATION (%)	OTHER (%)	TOTAL (%)
Immediately after the birth	11.8	18.6	*	*	(2.9)	13.9
After follow-up visit to women's consultation	55.4	22.0	*	*	(34.3)	45.5
After menses returns	7.4	1.7	*	*	(0.0)	5.2
When sexual relations start	11.3	45.8	*	*	(0.0)	16.1
Other	7.4	5.1	*	*	(22.9)	8.7
Not sure	6.9	6.8	*	*	(40.0)	10.6
Total	100	100			100	100
Number of respondents**	204	59	3	9	35	310

* Estimates based on less than 25 cases omitted
( ) Estimates based on 25-49 cases
** Excludes 107 clients planning to use LAM

Key WIN Indicator

2nd round:

67.0% of antenatal clients can correctly define 'exclusive breastfeeding'

Baseline:

56.0% of antenatal clients can correctly define 'exclusive breastfeeding'

6. DELIVERY AND POSTPARTUM CARE FOR WOMEN

Providers of Maternity and Neonatal Care

We questioned medical staff in maternities who said they provide care for mothers during delivery and postpartum, and those who provide care for neonates and advice about newborns to mothers in maternities. In the follow-up survey we wanted to document changes in the 'usual' practices in participating facilities, as well as changes in knowledge and attitudes held by these staff about breastfeeding and other subjects. We also included neonatologists and pediatricians who work in children's polyclinics when examining provider knowledge and attitudes, since these specialists are responsible for much of the counseling women receive about infant feeding.

Table 6.1 shows the distribution of medical staff interviewed about delivery care and care for neonates.

Table 6.1 Number of providers of different service by specialty and type of facility

Service Provided	Specialty of Provider					
	Obstetrician/ Gynecologist	Neonatologist/ Pediatrician	Midwife	Children's Nurse	Other	Total
In Maternity:						
Care for mothers	67	3	41	2	0	113
Care for neonates	30	37	23	22	1	113
In Polyclinic:						
Care for neonates	0	84	0	27	10	121

Provider Practices

Restriction to lying in bed during labor is now known to extend the duration of labor, on average, and may adversely affect the condition of the fetus and the progress of labor. Other practices that may be unnecessary or of unproven effectiveness were also investigated. We asked delivery caregivers what restrictions they impose on their patients during labor and delivery.

Delivery/Postpartum Care for Mothers

While physicians are allowed to exercise their clinical judgement to some degree, most maternity hospitals have strict procedural guidelines for care. Delivery care providers were asked to report what routine preparations for delivery and care during normal labor and delivery were followed in their facilities. The question was phrased to allow providers to indicate those procedures that are applied to virtually all women as well as those carried out on the basis of provider judgment (i.e. only when indicated). In Table 6.2 their responses are displayed.

The prevalence of certain practices that are not evidence-based has declined markedly since the baseline survey. Perineal shaves were nearly universal, and enemas and pain relief medication also very prevalent at baseline. Now, almost 80% of providers say that enemas and perineal shaves are <u>not</u> routine procedures, and less than 5% say that pain medication is routine for all patients (as compared to 75% at baseline).

Most providers (84%) say they do not restrict oral fluids for women in labor, and less than 2% say this is a routine practice for women delivering in their facility. More than 80% of providers also report that women are allowed to assume a sitting position during labor or delivery. More

than 94% of delivery caregivers report that the partogram, a method of monitoring progress during labor, is used routinely in their facility. (This compares with only 30% of providers who said at baseline that the partogram is used routinely for all women.

Table 6.2 Percent of providers reporting usual practices in maternity care

	PROVIDERS (%)		
	YES	ONLY FOR SOME WOMEN	NO
Perineal shave	4.4	15.0	80.5
Axillary shave	1.5	9.7	88.5
Enema	2.7	18.6	78.8
IV solution	1.8	92.9	5.3
Medicine to induce labor	0.9	98.2	0.9
Medicine for pain relief	4.4	92.0	3.5
Restricted to bed rest	0.9	42.5	57.5
Artificial rupture of membranes	0.0	90.3	9.7
Restrict foods*	4.5	17.1	78.4
Restrict oral fluids	1.8	14.2	84.1
Episiotomy	0.0	92.0	8.0
Monitor labor with special equipment**	8.9	76.8	14.3
Monitor labor with partogram**	94.6	3.6	1.8
Allow women to walk	85.0	15.0	0.0
Allow women to sit up	82.3	17.7	0.0
Allow close person to be present during birth	96.5	3.5	0.0
Number of respondents	113	113	113

* N=111
** N=112

Classification of 'high risk' women

Some of the above procedures are aimed specifically at women whose pregnancy is designated as 'high risk' in terms of expected complications for either mother or neonate. Some, such as allowing a family member to be present, or ambulation during labor, are not permitted for 'high risk' cases.

We examined the number of providers who had responsibility for any postpartum women. (Due to the low birth rate, 40% of these providers said they had no postpartum women in their care on the day of interview). Of the remaining 68 providers, 57% said that they had women designated as 'high risk' in their care. (See Table 5.5 for conditions antenatal caregivers frequently use to designate high-risk pregnancies.)

Neonatal care practices at time of delivery

When the baby is born, a number of procedures are carried out; some of these practices have been shown to improve the outcome or the subsequent care of newborns, while the value of others is unproven or potentially harmful. Tight swaddling, for example, is now discouraged, as is routine suctioning with a catheter[7] and bathing or cleaning the baby with oil should be postponed until 2 to 6 hours after birth, and only when the newborn's temperature is stable[8]. In regions where gonorrhea is prevalent, prophylactic eye treatment is recommended as routine practice, but there is no evidence that prophylactic treatment of the newborn's genitals is beneficial.

Reports from providers responsible for care of the newborn in maternities show that some of these practices are very widespread for all newborns (Table 6.3). These include swaddling the infant (70% do this for all neonates), weighing the baby (80%), and prophylactic treatment for eyes or (in the case of females also) genitals (74% and 51% respectively). Fourteen percent of providers report that none of the newborns in their facility are weighed, a procedure that should be performed within one to two hours after birth to provide a baseline to monitor normal postnatal weight loss.

Almost a quarter of neonatal caregivers report that an APGAR score, used to assess the physical condition of the newborn, is not recorded for any of the neonates in their care. This has hardly changed from the baseline survey.

Table 6.3 Usual care for newborns in maternity care facilities

	PROVIDERS (%)		
PROCEDURE	ALL NEONATES	SOME NEONATES	NONE
APGAR score recorded	73.2	2.7	24.1
Clean baby with oil	47.3	22.3	30.4
Suction with catheter	9.8	64.3	25.9
Swaddling	69.6	13.4	17.0
Prophylactic eye treatment*	73.9	4.5	21.6
Prophylactic treatment of genitals**	50.9	17.3	31.8
Weighing of baby	79.5	6.3	14.3
Immediate skin-to-skin contact	75.0	12.5	12.5
Immediate breastfeeding	82.1	13.4	4.5
Number of respondents	112	112	112

* N=111
** N=110

Provider attitudes and beliefs about care and feeding of the neonate

Experts now believe that that restricting a mother's contact with her infant in the hours and days after delivery can lead to less affectionate maternal behavior. Restrictions on maternal – newborn contact have also been shown to reduce the duration of successful breastfeeding[9]. Nevertheless,

[7] World Health Organization (1997) *Essential Newborn Care and Breastfeeding: Workshop Proceedings*, Geneva: WHO
[8] Personal communication, Pauline Glatleider, consultant midwife.
[9] Enkin, Keirse, Neilson, et al, *A guide to effective care in pregnancy and childbirth*, 3rd Edition, Oxford: Oxford University Press, 2000, based on the systematic reviews of evidence developed for the Cochrane Library.

while 75% of neonatal care providers say that immediate skin-to-skin contact for mother and baby is standard practice for all neonates, and more than 12% say that this is never done in their facility (Table 6.3).

All neonatal and delivery caregivers (in both maternities and polyclinics) were also asked their attitudes toward breast-feeding and skin-to-skin contact between mother and baby. Nearly all delivery and neonatal care providers (91%) report that a mother should be given her baby (skin-to-skin contact) immediately after delivery. Only 12-13% of neonatal and delivery care providers think the mother should keep the baby 'as long as she wants'.

One of the major changes the WIN Project tries to effect is the attitude toward and practice of exclusive breastfeeding among hospital staff and mothers. To assure the optimal chance of successful breastfeeding, counselors recommend that babies be put to the breast immediately after delivery, and at most, not more than an hour following delivery.

We see from the data in Table 6.3 that 75% of providers say that putting the baby to the breast immediately is routine in their facility.

In Russia, most infants are still routinely segregated in central nurseries. 'Rooming-in,' when the baby and mother stay together in the same room 24 hours a day, is a recent innovation. We asked all providers of delivery and neonatal care whether they themselves offer 'rooming-in' to their patients (Table 6.4). More than 94% of caregivers working in maternities say they offer this option to their patients. However, only one quarter of providers report that there are no contraindications for mothers to have babies with them day and night. When asked what contraindications would prevent a mother 'rooming-in' with her infant, the majority of providers said that mother or infant illness would be a reason to separate a mother from her newborn, but very few (3%) providers said that a Cesarean delivery was a contraindication, a change from the 25% who reported at baseline that a Cesarean section was a contraindication.

Table 6.4 Main contraindications for rooming-in

	YES (%)	
	DELIVERY CARE PROVIDERS	NEONATAL CARE PROVIDERS*
Rooming-in offered to patients	94.7	95.5
Number of respondents	113	112
Contraindications:		
Mother is ill	59.8	48.2
Child is ill, weak, or premature	53.6	46.4
Mother does not want	3.6	11.6
Mother is in intensive care	0.0	41.1
Baby is in intensive care	14.3	45.5
Cesarean birth	2.7	0.9
No contraindications**	25.9	22.3
Other	8.0	7.1
Don't know	2.7	0.0
Number of respondents	112	112

* Excludes neonatal care givers in children's polyclinics

** One delivery care provider and two neonatal care providers mentioned 'no contraindications' AND one of the contradictions listed

Advice on infant feeding

All delivery and neonatal care providers were asked if they counseled women about breast-feeding. Eighty one percent of delivery care providers and 73% of neonatal caregivers reported that they counsel postpartum women about how to breast-feed.

Among the common recommendations, almost all of neonatal caregivers (99%) and delivery caregivers (98%) report that they recommend exclusive breastfeeding to their clients (Table 6.5). Only 10% of the delivery care providers and 7% of the neonatal care providers also recommend that a mother wash her nipples each time she breastfeeds. Most providers also agree that women should feed 'on demand' rather than on a set schedule. Very few neonatal caregivers (less than 1%) (who are those most frequently cited by women as resources for breast-feeding advice) and only 5% of delivery caregivers recommend supplementing breast milk with water.

Table 6.5 Usual breastfeeding recommendations to postpartum clients

	YES (%)	
	DELIVERY CARE PROVIDERS	NEONATAL CARE PROVIDERS
Counsel women about breastfeeding	81.4	72.8
Number of respondents	113	232
Recommend the following to mothers*:		
Exclusive breastfeeding	97.8	99.4
Supplementing with formula	0.0	**5.4
Supplementing with water	5.4	***0.6
Increasing milk supply by feeding on demand	96.7	95.9
Breastfeeding on a schedule	2.2	1.8
Restricting duration of breastfeeding	2.2	2.4
Washing nipples at each breastfeed	10.9	6.5
Number of respondents	92	169

* Column percentages do not add up to 100 because multiple responses were allowed

** N=168

*** N=166

Note: Nine neonatal providers and three delivery care providers recommend both exclusive breastfeeding AND supplementing. Three neonatal providers and two delivery care providers recommend both breastfeeding on demand AND on schedule.

The majority of both delivery and neonatal care providers (over 95%) say that babies should be put to the breast in the first hour after birth (Table 6.6).

Table 6.6 Advice on timing of first breastfeeding

	YES (%)	
	DELIVERY CARE PROVIDERS	NEONATAL CARE PROVIDERS
Begin breastfeeding:		
During first hour after birth	96.5	95.3
One to six hours after birth	2.7	0.4
Seven to twelve hours after birth	0.0	0.4
More than twelve hours after delivery	0.0	0.4
Other	0.9	3.4
Total	100	100
Number of respondents	113	232

Caregivers were also asked their opinion about the frequency of breast feeds. Ninety-eight percent of delivery care providers said they recommend feeding 'on demand', and 97% of neonatal care providers gave this response. Advice these providers give to mothers about supplementation (when they tell mothers to start giving anything other than breast milk) ranges widely among both groups of caregivers, as the data shown in Table 6.7 suggest. Very few neonatal or delivery caregivers advise some kind of supplementation before the infant reaches six months of age. More than 60% of delivery caregivers and almost 80% of neonatal caregivers advise supplementation at 6 months.

Table 6.7 Advice on when mothers should supplement breastfeeding

	PROVIDERS (%)	
	DELIVERY CARE	NEONATAL CARE
Begin supplementing at:		
< 1 month	0.0	0.0
1 month	0.0	0.0
2 months	0.0	0.6
3 months	5.4	0.6
4 months	3.3	2.4
5 months	1.1	1.2
6 months	62.0	77.5
7-9 months	23.9	14.2
Other	4.3	3.6
Total	100	100
Number of respondents	92	169

When asked what conditions might contraindicate breastfeeding, 67% of neonatal caregivers and 77% of delivery care providers gave mother's illness as a reason (Table 6.8). Child illness or prematurity also accounted for a large number of responses to this question; more than 48% of neonatal caregivers and 57% of delivery caregivers said that a weak or ill baby was reason not to breast-feed. Even after the WIN interventions, few providers who counsel mothers about breastfeeding believe that there are no contraindications (12% of delivery care providers and 21.6% of neonatal care providers), although this is a far higher proportion than at baseline 94% and 1% respectively).

Table 6.8 Conditions under which breastfeeding is contraindicated

	PROVIDERS (%)	
	DELIVERY CARE	NEONATAL CARE
Mother is ill	77.2	66.8
Child is ill or weak	56.5	48.3
Baby is premature	15.2	15.1
Nipple/breast problems	1.1	5.2
Cesarean birth	1.1	2.6
Mother does not have enough milk	0.0	0.4
Mother does not want to	4.3	3.9
Baby refuses	1.1	1.3
Other reasons	14.1	14.2
No contraindications	12.0	21.6
Don't know	1.1	0.0
Number of respondents	92	232

Note: One delivery care provider and six neonatal care providers mention both no contraindications AND at least one contraindication

Finally, we examined these providers' ideas about what actually constitutes 'exclusive breastfeeding' and for how long they recommend it. Ninety seven percent of neonatal caregivers and 91% of delivery care providers replied that they recommend feeding breast milk and nothing else except vitamins, minerals, or medicine for the first six months.

Key WIN Indicators

2nd round:

Of those who counsel on breastfeeding, 97% of neonatal caregivers and 91% of delivery caregivers recommend exclusive breastfeeding for the first six months

Baseline:

Of those who counsel on breastfeeding, 28% of neonatal caregivers and 27% of delivery caregivers recommend exclusive breastfeeding for the first six months

Postpartum Client Experiences and Perceptions

Postpartum women were interviewed in maternities shortly before discharge (99%), or when visiting a children's polyclinic (0.9%) or women's consultation center (0.2%) shortly after the birth. One interview was incomplete and two women refused to be interviewed. Four hundred and forty-six women completed the interview.

Four hundred and forty six women were interviewed during the postpartum period. Most of these women (99%) were interviewed very close to their day of discharge from a maternity ward. Five were bringing their infants for neonatal check-ups at children's polyclinics, or attending a women's consultation.

Fertility intentions

We can see from Table 6.9 that the intentions of these women, interviewed in the immediate postpartum period, are somewhat different from those of antenatal clients (compare with Table 5.10). While few women want to wait less than three years until their next birth, 32% of women

in the middle age group – 25 to 34 – are sure, shortly after their delivery, that they want no more children. Forty percent of women of this age say they don't know how long they want to wait until the next birth. More postpartum women in the youngest age group say they want no more children when they are compared with antenatal clients between 15 and 24 (34% of postpartum compared with 10% of antenatal clients in this age group).

Table 6.9 Future pregnancy intentions by age group

	10-YEAR AGE GROUPS			
	15-24 (%)	25-34 (%)	35-45 (%)	ALL AGES (%)
Wait three years or less	14.2	13.0	(3.4)	12.9
Wait more than three years	37.0	14.6	(0.0)	24.9
Want no more children	33.8	31.9	(10.3)	31.4
Don't know	15.1	40.5	(86.2)	30.7
Total	100	100	100	100
Number of respondents*	219	185	29	433

* Excludes 13 clients who report having no regular partner
( ) Estimates based on 25-49 cases

Contraceptive experience

We also see from the data displayed in Table 6.10 that only 21% of postpartum women report that they became pregnant while using a contraceptive method. Most of these women were using methods that are very effective if used properly. Almost 40% were using reversible medical methods of contraception, and 41% were using condoms. Less than 15% were using traditional, and less effective, methods to prevent pregnancy. Only about 20% of postpartum clients using barrier methods became pregnant while actually using the method; two-thirds of those using traditional methods became pregnant while using the method.

Table 6.10 Distribution of last method used by whether pregnancy occurred while using the method

	% ALL USERS USING EACH METHOD	% OF USERS OF EACH METHOD WHO BECAME PREGNANT	% OF USERS OF METHOD TYPE WHO BECAME PREGNANT
Medical reversible	N=104	N=5 (4.8%)	4.8
Pills	23.2	7.6	
IUD	13.0	(0.0)	
Injection	0.0	0.0	
Post-coital pill	0.4	*	
Barrier	N=142	N=29 (20.4%)	20.4
Condoms**	41.4	18.6	
Spermicide/creams/jelly	8.4	(29.2)	
Diaphragm/cervical cap	0.0	0.0	
Traditional	N=39	N=26 (66.6%)	66.7
LAM	0.0	0.0	
Douching	5.6	(62.5)	
Rhythm method	7.7	(72.7)	
Other	0.4	*	
Total	100		21.1
Number of respondents	285		60

* Estimates based on less than 25 cases omitted
( ) Estimates based on 25-49 cases
** Includes users of condoms and spermicides together

We next asked women about their birth experience. Table 6.11 shows that the prevalence of Cesarean section deliveries varied among the three cities, with 20% of women in Perm reporting that they had a Cesarean delivery, while fewer in Veliky Novgorod (15%) and even fewer in Berezniki (7%) reported that their delivery was by Cesarean section.

Table 6.11 Percent of postpartum women reporting delivery by city of residence

	CASES (%)			
	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Cesarean sections	15.4	19.6	6.5	15.7
Vaginal deliveries	84.6	80.4	93.5	84.3
Total	100	100	100	100
Number of respondents*	117	235	93	445

* Excludes one client who reported giving birth at home

The reasons for a Cesarean section are quite varied, ranging from almost 21% of women who said that a previous Cesarean section was the reason for the recent one to 13% who said prolonged labor, and 26% who said a big baby was the reason.

Table 6.12 Percent distribution of reasons for Cesarean section

REASON	CLIENTS (%)
Fetal distress	0.0
Pregnancy-induced hypertension	5.7
Prolonged labor	12.9
Prolonged pushing	2.9
Baby too big	25.7
Pervious Cesarean	21.4
Other	31.4
Total	100
Number of respondents	70

Only four women who had a vaginal delivery reported that forceps were used.

We then asked all postpartum women the same questions about their routine care that we asked providers of care during delivery. Table 6.13 shows the responses of women in each city, but caution is urged in interpreting differences between cities because sample size is small.

Table 6.13 Practices during labor and delivery reported by clients

	YES (%)			
	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Perineal shave*	71.0	27.7	45.2	42.7
Axillary shave**	41.0	22.1	50.5	33.0
Enema	66.7	10.6	8.6	24.9
IV solution	59.8	58.7	48.4	56.9
Medicine to induce labor	32.5	27.2	32.3	29.7
Medicine for pain relief	58.1	40.0	53.8	47.6
Restricted to bed rest	17.1	12.8	17.2	14.8
Restricted in what you could eat	23.9	15.3	18.3	18.2
Restricted in what you could drink	13.7	8.5	22.6	12.8
Artificial rupture of membranes	51.3	51.9	30.1	47.2
Had an episiotomy	10.3	25.1	2.2	16.4
Ambulatory during labor	68.4	88.5	83.9	82.2
Not allowed to sit up	17.9	13.2	8.6	13.5
No close person supporting at birth	71.8	72.3	50.5	67.6
Prefer no close person at next birth	45.3	46.4	26.9	42.0
Number of respondents***	117	235	93	445

* Between 25% and 44% reported that they themselves had done the shave at home

** Between 22% and 51% reported that they had performed the underarm shave at home

*** Excludes one client who reported giving birth at home

More than half of women in Veliky Novgorod and Berezniki, and more than 40% of women in Perm reported that they were given pain medication. Of these women, only 63% reported that they wanted the pain relief medication (data not shown).

Eighty-two percent of women reported that they were allowed to walk while in labor (up from 67% at baseline). Only 14% percent of women reported that they were not allowed to sit up during labor, down from 56%. Some of these practices appear to vary widely from city to city.

Forty-two percent of postpartum women reported that their antenatal care provider told them they had problems with their pregnancy. Of these women, almost all were told what the problems were, and Table 6.14 displays the distribution of reasons that women reported. Forty percent of women who were classified as 'high risk' said that they risked a pre-term delivery. Oedema (16%), gestosis (including hypertension of pregnancy) (10%) and anemia (13%) were other frequently cited reasons. Gestosis, a diagnosis not frequently encountered outside Russia, refers to a variety of hypertensive disorders of pregnancy, including pregnancy-induced hypertension or pre-eclampsia.[10]

[10] Pauline Glatleider, consultant midwife, personal communication.

Table 6.14 Distribution of problems during pregnancy*

REASON	CLIENTS (%)
Risk of loss of a pregnancy	38.3
Gestosis**	10.0
Oedema	16.1
Renal disease	0.0
Toxicosis	2.8
Albuminuria	3.3
Anemia	13.3
High arterial pressure	9.4
Pyelonephritis	3.3
Don't remember	2.2
Other	42.2
Number of respondents	180

* Columns do not add up to 100% because multiple responses were allowed
** See previous paragraph for explanation

Family-centered maternity care

Some of the main characteristics of "maternity care oriented toward participation of family members" (FCMC) are closer contact between mother and baby (including 'rooming-in' and immediate, exclusive breastfeeding), more involvement by other family members in antenatal preparations, and support during labor and delivery and in the postpartum period.

About thirty percent of women reported that their husband or a close person was present during labor or birth (Table 6.13), while at baseline only 4% reported such support. Almost 60 % of all women report that they would like a close person present if they have another birth (Table 6.15). Their choice of a support person is shown in Table 6.15. At the time of the survey about 40% of women said they would prefer no one close to them to be present during delivery. Although the idea is still quite new, these data suggest that it is becoming more acceptable to women in these cities.

Table 6.15 Women's choice of support during labor

	CLIENTS (%)
Had no close person present at birth	67.6
Support preference, if another birth:	
No one	42.0
Baby's father	41.1
Other family member	9.4
Friend	0.9
Don't know	6.5
Number of respondents*	445

* Excludes one client who reported giving birth at home

Eighty percent of postpartum women reported receiving information about family-centered maternity care before the birth (compared with 25% at baseline), and of these, 33% reported choosing this option.

Of all postpartum women interviewed, 82% reported that their baby stayed in their room day and night ('rooming-in'), and only 9% of these women reported that the baby was taken to a nursery for the first night after birth (Table 6.16). Of the small number of women who did not have 'rooming-in', 44% reported being offered the option. The remaining 56% said they were never offered the option of 'rooming-in'. Around 95% of providers told us that they offer this option to their patients (Table 6.4).

Table 6.16 Postpartum clients reports of 'rooming-in' experiences

ROOMING-IN EXPERIENCE	CLIENTS (%)
Had baby with her night and day	81.8
Number of respondents	446
Of those who had rooming in:	
• **Baby taken to nursery 1st night**	9.0
Number of respondents	365
Of those who did not have rooming-in:	
• **Offered rooming in option**	44.4
Number of respondents	81

As mentioned earlier, skin-to-skin contact between mother and baby assists early bonding of mother and baby and is now widely recommended. We see that almost 90% of all women report that they did experience such contact immediately after the birth, compared with only 55% at baseline. Nevertheless, 7% of women who were about to be discharged from the maternity reported not yet having such contact.

Table 6.17 Timing of first skin-to-skin contact

	CLIENTS (%)
Immediately	89.9
Within 24 hours	2.5
24 hours or more	0.2
Not yet	6.5
Don't know	0.9
Total	100
Number of respondents	446

Breast feeding attitudes and practice

Now we turn to examine reports of postpartum women about their experiences of breastfeeding. The data shown in Table 6.18 show some variations between cities, but these differences should be interpreted cautiously given the small number of respondents in each city. Almost 95% of women say their caregivers recommended exclusive breastfeeding, and very few say they were advised to supplement breast milk with baby formula. Very few postpartum women (2%) were advised to supplement with water. Very few breastfeeding counselors (5 % of delivery care and 1% of neonatal care providers) say they advise supplementing with water (Table 6.5). Women could answer 'yes' to each item, and very few said that they received conflicting advice: to increase milk supply by feeding on demand and to schedule feeding times. Only about 20% of women were instructed to wash their nipples at each feeding, and slightly fewer women in Berezniki report this recommendation (10%). These data indicate that providers are recommending that mothers implement only evidence-based practices regarding breastfeeding.

Table 6.18 Breastfeeding recommendations from facility staff reported by women*

	YES (%)			
	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Exclusive breastfeeding	81.2	99.1	100.0	94.6
Supplementing with formula	8.5	1.3	0.0	2.9
Supplementing with water	4.3	0.9	0.0	1.6
Increasing milk supply by feeding on demand	72.6	94.5	88.3	87.4
Breastfeeding on a schedule	10.3	3.4	0.0	4.5
Restricting the duration of breastfeeding	6.8	0.9	3.2	2.9
Washing the nipples at each breastfeed	34.2	21.3	9.6	22.2
Number of respondents	117	235	94	446

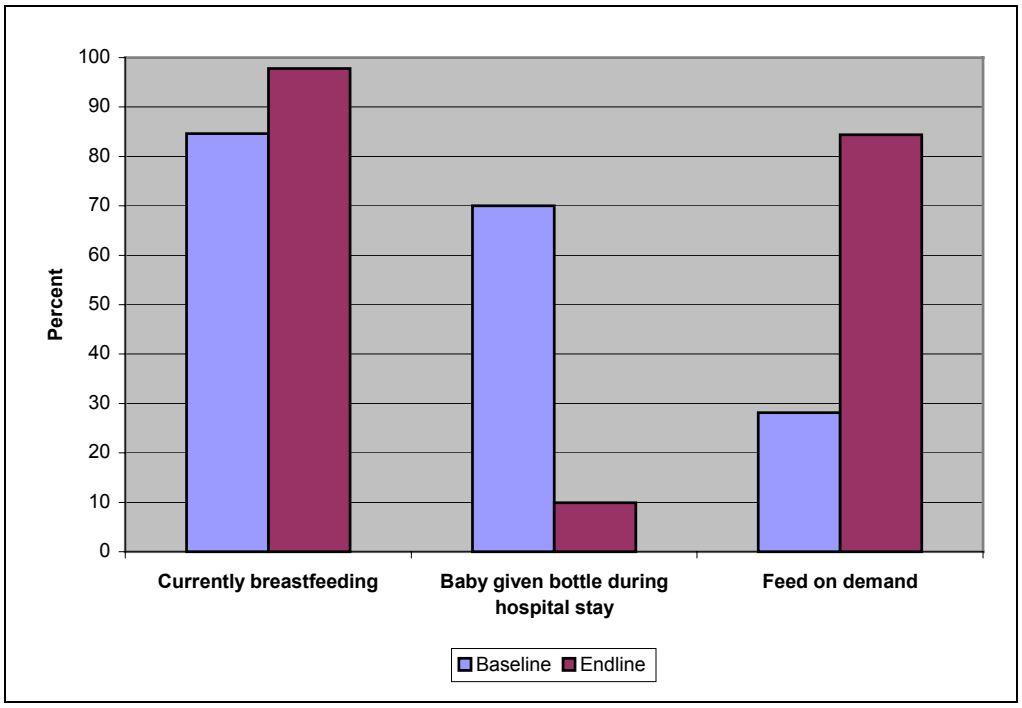
* Columns do not add up to 100% because multiple responses were allowed

In Figure 6.1 we see that almost 98% of postpartum women reported that they are currently breastfeeding, and only 10% of these women say their baby was given something else besides breast milk to drink during their hospital stay. Only 14% of women report feeding on a fixed schedule, compared with nearly two-thirds at baseline and nearly 85% of breastfeeding women say they feed 'on demand'.

Table 6.19 Breastfeeding practices reported by postpartum women

	CLIENTS (%)
Currently breastfeeding	97.8
Number of respondents	446
Of those currently breastfeeding:	
Baby given drink from bottle during hospital stay	9.9
Frequency of breastfeeds	
On schedule	14.0
On demand	84.4
As often as they bring baby	1.6
Number of respondents	436
Timing of first breastfeed	
Immediately	86.5
Within 1-24 hours	8.5
More than one day after delivery	0.7
Don't know/did not breastfeed	4.3
Number of respondents	446

Figure 6.1 Postpartum women's breastfeeding practices



Almost eighty six percent of all postpartum women report that they first breast-fed their baby within an hour of delivery, and less than one percent of women report that the first feed did not occur until more than 24 hours after delivery.

Among the 10 women who were not breastfeeding, eight reported that the reason for not breastfeeding was that the child was ill or weak or had died and 2 responded 'other'.

Postpartum women were also asked who was the best source of advice about breastfeeding. Like antenatal clients (Table 5.16), more than 60% answered that a pediatrician or neonatologist was the best person to consult (Table 6.20).

Table 6.20 Postpartum clients opinion on sources of breastfeeding advice

Best person to consult about breastfeeding	CLIENTS (%)
Obstetrician	10.3
Neonatalogist/pediatrician	65.5
Midwife	3.8
Nurse	2.5
Friend	1.3
Family member	5.4
Breastfeeding support group	7.8
Other	1.8
Don't know	1.6
Total	100
Number of respondents	446

We asked these postpartum women to tell us what the term 'exclusive breastfeeding' meant to them. Eighty eight percent told us the 'correct' definition: breast milk and nothing else except vitamins, minerals or medicine.

Sixty-four percent said that a child should be six or seven months old before being given other food or drink in addition to breastmilk.

Key WIN Indicator

2nd round:

88% were exclusively breastfed on discharge

88% of postpartum clients can correctly define exclusive breastfeeding.

Baseline:

25% were exclusively breastfed on discharge

49% of postpartum clients can correctly define exclusive breastfeeding

Contraceptive knowledge and plans for postpartum use

As with our antenatal clients, almost half of postpartum women believe that breast-feeding can be used as a contraceptive (e.g. the lactational amenorrhea method, or LAM). Forty-six percent of all postpartum women said 'yes' to this question, but almost a quarter were unsure of the answer.

Half of all postpartum women reported that someone at the facility had discussed the LAM method with them, compared to only 12% at baseline. Almost one quarter of postpartum clients said that they were planning to use LAM (of those who knew which method they would use), doubling from baseline. Still, only two percent of these women know enough about LAM (all three conditions - baby less than 6 months, no menses, and exclusive breastfeeding on demand) to use the method effectively.

Table 6.21 Postpartum women's beliefs about breastfeeding as contraception

	CLIENTS (%)
Believe breastfeeding can be used as a contraceptive	
Yes	46.4
No	27.4
Don't know	26.2
Number of respondents	446
Know all three conditions when it is effective	1.9
Number of respondents	207
Provider at this facility discussed LAM	50.0
Number of respondents	446

Postpartum women were also asked what method of contraception they were planning to use. Almost two thirds of these women knew what method they would use, and almost half named a

medical method of birth control. The decrease from 75% at baseline planning to use a medical method can be partly explained by the new uptake of LAM, which is not included in our definition of 'a medical method'. Four percent said they would use sterilization – a tubal ligation or vasectomy. Although fifty percent of women had used a barrier method before this pregnancy, only twenty percent planned to use one in future, and very few (less than 1%) planned to use a traditional method of contraception.

Table 6.22 Plans for postpartum contraception

	CLIENTS (%)
Knows what contraceptive method she will use	62.1
Number of respondents	446
Distribution of Methods	
Medical	49.8
Barriers	19.9
LAM	25.3
Rhythm or withdrawal	0.4
Sterilization	4.3
Other	0.4
Number of respondents	277
Of those who plan to use method later, they plan to begin using	
Immediately after the birth	2.8
After a follow up visit	31.0
After my menses returns	3.5
When sexual relations start	20.4
Other	17.6
Not sure	24.6
Of those who plan to use method later, type of method they plan to use	
Medical	32.4
Barriers	7.0
LAM	2.1
Rhythm or withdrawal	2.8
Sterilization	0.7
Other	0.7
Don't know	54.2
Number of respondents	142

Few women said they planned to start using the method immediately. Almost 25% of these women were unsure when they would start contraceptive use and almost one third will delay use until they have a postpartum check-up.

Almost half of women who know what method they want to use (47.3%) said they were advised by their doctor to use the named method, 6% were advised by another woman, 6% by someone else, and 39% reported that no one had advised them to use the method. Ninety-five percent reported that the method they planned to use was their method of choice.

Of those who did not already know which method they would use, 83% were planning to use a contraceptive method at some later date and, while more were unsure of the method they will use, almost one third reported wanting to use a reversible medical method. However, more than half don't know what method they will use.

Key WIN Indicator

2nd round:

62% of postpartum clients know what contraceptive method they will use.

74 % of these clients report they will use a modern method of birth control postpartum (medical, reversible or sterilization, barrier) and 50 % will use a medical method. Twenty-five percent will use LAM.

Baseline:

51% of postpartum clients know what contraceptive method they will use.

93 % of these clients report they will use a modern method of birth control postpartum (medical, reversible or sterilization, barrier) and 72 % will use a medical method. Only 2 of 324 postpartum respondents said they would use LAM.

7. CONTRACEPTION AND CONTRACEPTIVE COUNSELING

Provider Knowledge and Attitudes

Almost two thirds of providers (61%) said that they gave information and counseling about contraceptives to women attending their facility, but the proportion of women's health care providers who do so varies by city, and by the type of facility where they work and their specialty training. Table 7.1 shows these distributions.

Providers in children's polyclinics (neonatologists/pediatricians and infant nurses) were least likely to do contraceptive counseling, while eighty percent of providers working in hospital gynecology units said that they do such counseling (Table 7.1).

Table 7.1 Percent of providers who counsel clients about contraceptive use

	COUNSELS ABOUT CONTRACEPTIVES		
PROVIDER CHARACTERISTICS	YES	NO	N=
City			
Veliky Novgorod	42.9	57.1	184
Perm	70.1	29.9	251
Berezniki	75.0	25.0	68
Type of health facility			
Maternity	50.3	49.7	193
Hospital gynecology unit	82.3	17.7	62
Women's consultation	93.7	6.3	95
Children's polyclinic	34.1	65.9	123
Family planning center	(89.7)	(10.3)	29
Other	*	*	1
Medical specialty			
Obstetrician or gynecologist	94.8	5.2	211
Neonatologist or pediatrician	35.8	64.2	123
Midwife	44.2	55.8	77
Infant nurse	24.0	76.0	50
Other	(34.9)	(65.1)	42
Total	60.8	39.2	503

* Estimates based on less than 15 cases omitted

( ) Estimates based on 25-49 cases

Women's health providers in Veliky Novgorod are less likely to report that they do contraceptive counseling than do providers in other cities. Only about half say they counsel, compared to more than 70% of providers in Perm and Berezniki. These providers were then asked which methods they most commonly discussed with clients, and for specific methods, what counseling they gave. A major change from baseline is the one-third of providers working in children's polyclinic, who say they counsel about family planning. This figure was only 6% at baseline, and the increase probably reflects the success of breastfeeding training and integrated counseling training, which emphasizes the importance of family planning and the use of LAM by new mothers.

The data in Table 7.2 show the methods mentioned by providers in order of frequency. Oral contraceptives, condoms, IUDs, and LAM were the methods most often mentioned by providers as those they recommend; about 8 of every 10 providers mentioned these methods. Next most common methods mentioned were spermicide cream or jelly and natural family planning, two

methods whose efficacy rely heavily on utilization practice. The next two common recommendations were more effective methods – almost half mentioned hormonal injectable methods. Tubal ligation (female sterilization) is also mentioned by almost half of all providers, which is surprising in light of the reports from other sources that few women have received such methods. (Less than 2% of women in these cities were currently using this method, according to the baseline data[11]).

Of note, seventy-eight percent of providers say they discuss the lactational amenorrhea method of contraception, up from 40% at baseline. At the same time, there is some level of discrepancy in this information between providers and clients. While almost 80% of providers report that they counsel their clients on LAM, only 42% of antenatal clients and one half of postpartum clients mentioned hearing about LAM from a health care provider (Tables 5.17 and 6.21).

Table 7.2 Methods providers most commonly discuss with clients, in order of prevalence

METHOD	MENTIONED (%)
Pills	81.7
Condoms	81.4
IUD	79.4
LAM	77.8
Spermicide/cream/jelly	65.0
Natural family planning	53.3
Tubal ligation	52.0
Injections/Depoprovera	47.7
Diaphragm/cervical cap	20.3
Implants/Norplant	19.9
Vasectomy	16.3
Other	0.3
Number of Respondents	306

Those providers who mentioned oral contraceptives were asked what accompanying advice they give to women who will use the method. Results are displayed in Table 7.3.

[11] David, *et al*, (2000) *Women and Infant Health Project Household Survey 2000: Report of Main Findings*, Boston: John Snow, Inc., December.

Table 7.3 Percent of providers who report giving different types of advice to pill users

ADVICE GIVEN	PROVIDERS (%)
When in cycle to begin taking the pill	
Within first 5 days of menstrual bleeding	94.8
Other answers	4.0
Don't know/missing	1.2
STD advice to at-risk pill users*	
Continue to use pill alone	3.2
Continue with the pill but use a condom	88.0
Switch from the pill to the condom	8.0
Stop using any type of contraception	0.0
Counsel client on STDs/HIV or refer for counseling	20.8
Other	1.6
Unsure/Don't know	1.2
Symptoms for which user should return to doctor*	
Chest pain/shortage of breath	32.0
Headache	45.6
Vision loss or blurring	18.8
Abdominal pain	42.8
Leg pain	42.4
Excessive/frequent bleeding	75.2
Spotting	43.6
Late menses	52.8
No Symptoms	1.2
Other	35.6
Number of respondents	250

* Percentages do not add up to 100 because providers could give more than one answer

Those who mention IUDs were also asked about specific advice they give. Their answers are displayed in Table 7.4.

Table 7.4 Advice providers report giving to IUD and injectable contraceptive users

	PROVIDER (%)
Symptoms for which IUD users should return to doctor:	
Heavy discharge	55.1
Abnormal spotting or bleeding	84.0
Expulsion or cannot feel threads	50.2
Abdominal pain	81.5
Late menses	57.6
Other	26.7
Number of respondents	243
Symptoms for which users of injectable contraceptives should return to doctor:	
Chest pain/shortage of breath	23.3
Headache	28.8
Vision loss or blurring	9.6
Abdominal pain	30.1
Leg pain	17.1
Excessive/frequent bleeding	80.8
Spotting	32.2
Late menses	39.7
Frequent urination	0.0
Depression	6.2
Other	13.0
Don't know	1.4
Number of respondents	146

Contraception for breast feeding women

Nearly 80% of providers report discussing LAM as a contraceptive method with their clients, a doubling from a baseline figure of 40%. Yet only 42% of antenatal clients and 50% of postpartum clients report hearing about LAM from their caregivers. However, this percentage is up from only 10% of each client type at baseline who reported hearing about LAM from their health care provider.

Seventy-five percent of providers report that they discuss a back-up method to use when LAM is no longer effective. When asked which method or methods they advise LAM users to adopt as a back-up method if they intend to continue to breast-feed, IUDs were the method most often cited (Table 7.5a) (76% of providers who named a method mentioned the IUD. IUDs were followed by condoms mentioned by 65%, and low-estrogen ("mini") pills mentioned by 52% of providers, respectively. Only 5% of providers mentioned other types of daily pills, all of which are contraindicated for breast feeding mothers. This figure is down dramatically, from 20% at baseline.

Table 7.5a Recommended method to succeed LAM for women who plan to continue breastfeeding*

PROVIDERS DISCUSS WHAT METHOD TO USE AFTER LAM IS NO LONGER EFFECTIVE	
Yes	75.3 (%)
No	24.7 (%)
Total number of respondents	255
METHOD	**OF PROVIDERS WHO COUNSEL (%)**
Mini-pills (low estrogen)	52.1
Regular pills	4.7
IUD	76.0
Injectable/Depoprovera	29.2
Tubal ligation	13.0
Condoms	65.1
Natural Family Planning	8.3
Other	15.6
Unsure/Don't know	0.0
Number of respondents	192

* Columns do not add to 100% because multiple responses were allowed

Table 7.5b When LAM users should adopt next method of contraception

	PROVIDERS (%)
When she is 6 months postpartum	75.0
When her menses return	54.2
When she starts to give the baby anything other than breast milk	52.1
Other	17.7
Number of respondents	192

* Columns do not add to 100% because multiple responses were allowed

LAM is no longer an effective method of contraception when any of the following conditions is met: when the baby reaches 6 months of age, when supplementation is introduced OR when menses return. The quality of counseling provided by those recommending LAM as a contraceptive method was examined by asking 'when should a postpartum woman start the back-up method?'

As we can see from Table 7.5b, one half to three quarters all providers mentioned each indication that LAM is no longer an effective method for a woman to use as a contraceptive.
Only 22% of these respondents (N=192) mentioned all three conditions (see Table 7.5b) and did not mention 'other' and did not mention 'don't know.'

All providers, regardless of whether they themselves provide contraceptive counseling were asked their opinion of the contraceptive method best suited to a breast feeding woman. LAM was the choice most frequently mentioned (51% of providers), followed by the IUD (21%). Only 4% of providers were unsure or did not answer, and none mentioned high estrogen brands of oral pills that are contraindicated for breastfeeding women. Condoms were mentioned by almost 16% of respondents, 5% mentioned mini-pills (brand name low-estrogen pills) and almost 2% mentioned 'natural family planning' (the rhythm method).

Table 7.6a Contraceptive methods best suited to women who intend to breastfeed*

METHOD	PROVIDERS WHO COUNSEL (%)	PROVIDERS WHO DON'T COUNSEL (%)	ALL PROVIDERS (%)
Mini-pills (low estrogen)	8.2	0.5	5.2
Regular pills	0.0	0.0	0.0
IUD	22.5	18.8	21.1
LAM	53.6	47.7	51.3
Injectable/Depoprovera	2.0	0.0	1.2
Tubal ligation	1.3	0.5	1.0
Condoms	14.1	18.8	15.9
Natural Family Planning	0.3	4.1	1.8
Other	0.3	1.5	0.8
Unsure/Don't know	0.7	9.6	4.2
Number of respondents	306	197	503

* Columns do not add to 100% because multiple responses were allowed

Table 7.6b When a postpartum woman should start using this method*

	PROVIDERS (%)
Immediately after the birth	55.2
When her menses return	7.5
When she starts to give her baby anything other than breast milk	7.9
When sexual relations resume	15.4
Six weeks after delivery**	19.3
Other**	9.6
Don't know**	0.6
Number of respondents	482

* Columns do not add to 100% because multiple responses were allowed
* N=481

Providers who counsel about contraception more often mention low-estrogen oral contraceptives (mini-pills) and LAM than providers who do not counsel about family planning (Table 7.6). Nevertheless, the level of awareness among those who counsel for low-estrogen pills as an option for breastfeeding mothers is still quite low.

Male involvement in family planning and reproductive health

All providers were also asked whether they had discussed family planning with a client's partner. Only 13% of all providers answered 'yes' to this question (Table 7.7).

Providers were also asked who should make the decision about which contraceptive method to use. Thirty-four percent responded that the woman and her partner should make the decision jointly, 36% thought that the woman alone should make the decision, and 8% thought the decision should be made by the woman and her doctor. Only five percent of providers answered that the doctor should make the decision alone, down from 17% at baseline. (These percentages do not add to 100 percent because providers were allowed to give multiple answers to this question.)

Table 7.7 Practice and attitudes of providers toward male involvement in family planning

	PROVIDERS (%)
Person(s) who should make the choice of contraceptive method:	
Woman alone	36.2
Her doctor	5.4
Woman and partner	34.4
Woman and her doctor	8.2
Other/not sure	15.9
Number of respondents	503
Discusses family planning with a woman's husband/partner	13.2
Believes that provision of reproductive health services to men will improve women's health	94.6
Supports providing reproductive health services for men in facility	65.0
Number of respondents	500

All providers were also asked if they thought that provision of reproductive health services to men would improve women's health. Almost 95% of those who responded answered 'yes' to this question. Nevertheless, fewer providers (65%) said they support the idea of providing reproductive health services to men at their own facility.

Client Contraceptive Counseling Experience and Attitudes

We also asked clients about their experience of counseling, if any, provided in the facility they were attending. As we see in Table 7.8, more than 40% of antenatal and postpartum clients report having discussed contraception with medical staff. Twice as many abortion clients (82%) had received counseling, consistent with the reports of 95% abortion providers that report talking to their clients about contraception at the time of the abortion procedure (Table 4.3).

In any case, women who do receive contraceptive counseling are satisfied with the way it is delivered. Nearly all clients said the information was conveyed to them in a respectful manner, and their questions were encouraged.

If they had received counseling from a provider at the facility, we also asked abortion and postpartum women more specific questions about the quality of that counseling. We asked: did the provider explain how to use the method, describe possible side effects or problems, and tell her what to do if she did experience problems. Ninety-four percent of postpartum women who were counseled and 91% of abortion clients who received counseling reported that their provider had discussed all three elements (Table 7.8).

Table 7.8 Client experience of contraceptive counseling by type of service

	ANTENATAL CLIENTS (%)	POSTPARTUM CLIENTS (%)	ABORTION CLIENTS (%)
Medical staff discussed contraception	41.8	46.9	82.1
Number of respondents	533	446	559
Presentation of pregnancy prevention information			
Information given respectfully	98.2	98.6	97.2
Questions encouraged	99.6	98.1	96.7
Partner participated	3.8	5.6	2.2
Number of respondents*	223	209	459
Provider described possible method side effects and problems	N/A	94.4	90.9
Provider explained what to do if client experienced any problems	N/A	93.6	90.9
Number of respondents		125	318
Want partner to participate in pregnancy prevention counseling	66.3	81.6	77.1
Number of respondents**	196	179	424
Ever discussed contraception with partner	79.7	76.2	80.0
Think men should have access to reproductive health services at this facility	81.2	***	77.6
Number of respondents	533	446	559
Where to seek advice about contraception (after leaving facility)			
Women's consultation center	89.1	89.9	82.1
Friend or mother	2.1	1.6	1.5
Family planning clinic	6.4	6.1	10.4
Other	1.1	2.0	4.4
Don't know	1.3	0.4	1.6
Number of respondents	533	446	****546

* Includes antenatal clients, postpartum clients, and abortion clients who report no regular partner

** Excludes clients who responded 'no' to question 301, those who report no partner, and those who reported that their partners participated in the counseling session

*** Not asked

****Excludes 13 clients who do not plan to use contraceptive methods now or later

More than three quarters of women had discussed contraception with their partners at some time in the past, and 69% of antenatal clients, more than 80% of postpartum women and more than 75% of abortion clients want their partners to participate in family planning counseling.

Differences between cities

When we look at differences between the cities (Table 7.9) we can see that Berezniki has highest proportion of abortion clients who report that contraceptive methods were discussed with them at the time of the abortion. Ninety-five percent of abortion clients in Berezniki report receiving counseling or information, 75% in Veliky Novgorod and 90% in Perm report such counseling. Contraceptive counseling for antenatal clients appears to be more typical in Perm and Berezniki than in Veliky Novgorod, while at the same time, fewer postpartum women in Perm receive counseling at the maternity as postpartum clients in Veliky Novgorod and Berezniki.

Table 7.9 Contraceptive counseling by city of residence and type of client

	CITY				
TYPE OF CLIENT	V. NOVGOROD (%)	PERM (%)	BEREZNIKI (%)	TOTAL (%)	N=
Antenatal (any visit)	18.9	56.9	35.8	41.8	533
Postpartum	45.3	39.1	68.1	46.9	446
Abortion	74.1	89.5	95.2	86.4	559

Key WIN Indicator

2nd round:

42% of antenatal clients, 47% of postpartum clients and 82% of abortion clients report receiving counseling on contraception, nearly doubling for every client type since baseline survey.

Baseline:

23% of antenatal clients, 19% of postpartum clients and 41% of abortion clients report receiving contraceptive counseling.

8. SEXUALLY TRANSMITTED INFECTIONS AND DOMESTIC VIOLENCE

The WIN Project wants to ensure that providers assess all clients for their risk of contracting a sexually transmitted diseases (STD). All providers were asked how they currently assess women for risk of sexually transmitted infections.

We see from the distribution of responses in Table 8.1a that about two thirds of all providers who counsel women about contraception said women with multiple partners are at risk of STDs. Other frequently mentioned responses were women who inject drugs or women whose partners do so. Women whose partners have other partners was mentioned by about 40% of providers (and 45% of those who do contraceptive counseling). These latter criteria may be more difficult to assess, especially if the woman herself is unaware of a partner's promiscuity or drug use. Nearly half of providers also gave other answers to this question.

Table 8.1a Percent of providers mentioning various criteria they use to assess whether a woman is at risk of sexually transmitted disease

CRITERIA USED TO ASSESS RISK*	PROVIDERS WHO COUNSEL ABOUT CONTRACEPTION (%)	ALL PROVIDERS (%)
If a woman's partner has other partners	44.8	40.2
If woman has more than one partner	80.7	66.6
If woman injects drugs	48.0	42.3
If woman's partner injects drugs	24.8	22.9
If she asks for a test	9.8	7.2
Not provider's responsibility	6.2	12.5
Other	50.3	46.1
Don't know	0.7	3.2
Number of respondents	306	503

* Columns do not add to 100% because multiple responses were allowed

Almost thirteen percent of all providers interviewed replied that such assessment of risk was not their responsibility.

Table 8.1b Percent of providers mentioning action taken if a sexually transmitted disease is suspected

ACTION TAKEN	PROVIDERS (%)
Order lab tests	58.4
Diagnose client	20.6
Treat client	25.5
Refer client for diagnosis	19.6
Refer client for treatment	9.7
Counsel client	14.4
Refer client for counseling	22.5
Inform partner or other exposed person	8.0
Arrange for follow-up visit after tests	13.0
Other	19.1
Don't know	0.9
Number of respondents*	432

* Excludes providers who report that STD assessment was not their job or did not know about the same

Among those who consider it their responsibility to take action if they identify a woman at risk, 58% said that they would order lab tests, diagnose her (21%) or refer her for diagnosis (20%) (Table 8.1b). Only 13% of providers would arrange for a follow-up visit after testing. Fourteen percent said they themselves would counsel the woman, and 23% would refer the woman to someone else for counseling.

Providers were also asked about what action they would take if they see a woman who shows signs of domestic violence (Table 8.2). More than one third (36%) replied that they do not see victims of domestic abuse, down from almost half of providers at baseline. Among other responses given, the most frequently cited action (18%) was to refer the woman to a special center for forensic tests (such centers are provided by the government in Russia), followed by 17% who would refer her to social services. Only about 12% said they would counsel the woman, 13 % would refer her to the militia (police) and 11% would refer her to a psychologist.

Table 8.2 Actions providers report they take in cases of domestic violence

	PROVIDERS (%)
Counsel client	11.9
Ask permission to talk to partner	0.8
Refer client to social services	16.7
Refer client to psychologist	10.5
Refer client to militia	13.3
Examine client	2.2
Refer client to special center for forensic tests	18.3
Other	7.0
Do not see victims of domestic violence	35.6
Don't know	3.4
Number of respondents	503

Client experience of domestic violence

Antenatal and abortion clients were asked if they themselves had experienced violence or threats of violence at the hands of their partners during the previous year. (Postpartum women were not asked these questions, because it was felt to be inappropriate at the time.) Three percent of antenatal clients and 6% of abortion clients said that they had been victims of such abuse (by either a partner or former partner), identical to baseline results (Table 8.3a). This is very similar to the proportion of women who reported experience of domestic violence in household surveys. Between 5% and 7% of women of reproductive age in these same cities reported experiencing threats or actual acts of violence at the hands of a partner during the previous year[12].

Table 8.3a Percent of clients who report having suffered domestic violence* within previous year

	YES (%)	NO (%)	NO ANSWER (%)	N=
Antenatal Clients	3.0	94.6	2.4	533
Postpartum Clients	N/A	N/A	N/A	
Abortion Clients	5.9	90.5	3.6	559

* Partner or former partner has ever pushed, shoved, or slapped, or hit client; threatened to hit client; or threatened client with a knife or other weapon

[12] David, *et al*, (2000) *Women and Infant Health Project Household Survey 2000: Report of Main Findings*, Boston: John Snow, Inc., December.

Of these women who reported abuse, 20% of antenatal clients and 40% of abortion clients reported that they did not seek help (Table 8.3b) This is a big improvement over baseline, when 81% of antenatal clients and 66% of abortion clients report not seeking help for abuse (Tables 8.3b and 8.3c). However, the number of women who reported being abused was small in both surveys.

Table 8.3b: Percent of clients who reported domestic abuse who did not seek help

2nd Round survey		**N**
Antenatal Clients	18.8	16
Abortion Clients	39.6	33
Baseline survey		**N**
Antenatal Clients	81.3	16
Abortion Clients	65.5	29

Client reports of risk behavior during pregnancy

The WIN Project also wants to know about the prevalence of various behaviors that, if practiced during pregnancy, can harm mother or the developing fetus. Sixteen percent of antenatal clients who are smokers report that they continue to smoke during pregnancy, but this amounts to only 7% of all antenatal clients. Eighty percent of postpartum clients report that they did not smoke during their pregnancy. Most of these clients report that they do not drink at all, or drink less than once a week, about the same pattern of drinking behavior reported at baseline.

Table 8.3c Risk behavior during pregnancy reported by clients

Risk Behaviors	**ANTENATAL CLIENTS (%)**	**POSTPARTUM CLIENTS (%)**
Smoking cigarettes		
Ever smoked cigarettes	42.6	N/A
Currently smoke (of 227 ever-smokers)	15.9	N/A
Smoked during pregnancy	N/A	21.3
Currently smoke (of 95 who smoked during pregnancy)	N/A	20.0
Frequency of drinking during pregnancy		
One to three times per week	1.1	2.4
Less than once per week	23.6	28.7
Not at all	75.2	68.8
Number of respondents	533	446

9. INFORMATION, EDUCATION AND COMMUNICATION

We also wanted to know how much information was provided to women through different communication channels in the pre-intervention period. All clients were asked if they had received any information through a variety of possible channels (Table 9.1).

Table 9.1 Percent of clients and providers (all services) reporting channels of information

INFORMATION CHANNELS	ANTENATAL (%)	POSTPARTUM (%)	ABORTION (%)	PROVIDERS (%)
Given/took brochure or educational material to read away from facility (client)	76.5	80.5	76.4	N/A
Gave material to woman to read (provider)	N/A	N/A	N/A	68.4
Attended a group talk today	31.7	38.8	47.9	N/A
Gave a group talk today	N/A	N/A	N/A	38.2
Saw any poster or information sheet at facility	95.9	96.0	90.0	N/A
Saw a video or TV presentation at facility	35.5	25.1	0.4	N/A
Number of cases	533	446	559	503

Table 9.2 Information topic by type of channel and type of client

INFORMATION CHANNEL AND SUBJECT	ANTENATAL (%)	POSTPARTUM (%)	ABORTION (%)
Brochure/Educational Material			
Antenatal care	21.8	0.6	0.0
Postpartum care	2.7	11.1	0.0
HIV/AIDS	9.6	6.4	8.7
STDs	11.8	6.1	14.1
Pregnancy prevention	55.9	51.0	98.1
Child care	10.8	36.8	0.5
Nutrition of women	29.7	9.7	2.1
Formula feeding	0.2	0.6	0.0
Exclusive breastfeeding	77.7	89.7	0.5
Maternity care oriented to family participation	10.5	1.1	0.0
Rooming-in option	2.9	2.2	0.0
Preparation for childbirth	9.3	2.5	0.0
Partner/family participation in childbirth	8.6	0.8	0.0
Alcohol use	1.7	0.3	0.9
Drug use	1.5	0.3	1.6
Domestic violence	0.0	0.6	0.0
Other	3.2	9.7	3.7
Don't know	0.7	0.0	0.2
Number of respondents	408	359	427
Group Talk			
Antenatal care	18.3	2.3	0.4
Postpartum care	6.5	7.5	0.4
HIV/AIDS	1.8	0.6	5.6
STDs	3.0	0.0	14.2
Pregnancy prevention	16.6	28.9	85.8
Child care	17.8	54.3	0.0
Nutrition of women	33.1	12.7	0.0
Formula feeding	0.0	0.0	0.0
Exclusive breastfeeding	47.3	44.5	0.4
Maternity care oriented to family participation	14.8	2.3	0.0

Rooming-in option	13.0	1.2	0.0
Preparation for childbirth	53.3	4.6	0.0
Partner/family participation in childbirth	15.4	1.7	0.0
Alcohol use	4.7	0.0	0.4
Drug use	3.0	0.0	0.4
Domestic violence	0.0	0.0	0.0
Other	2.4	14.5	31.7
Don't know	0.0	0.0	0.4
Number of respondents	169	173	268
Poster or Information Sheet			
Antenatal care	18.8	4.0	2.6
Postpartum care	4.7	13.1	0.8
HIV/AIDS	21.1	20.3	22.9
STDs	21.5	14.5	23.9
Pregnancy prevention	75.1	57.2	95.0
Child care	13.9	32.2	2.4
Nutrition of women	29.2	38.1	7.4
Formula feeding	0.0	0.9	0.0
Exclusive breastfeeding	86.5	93.9	17.9
Maternity care oriented to family participation	13.9	11.0	3.8
Rooming-in option	4.3	4.7	1.6
Preparation for childbirth	17.0	6.5	6.2
Partner/family participation in childbirth	14.5	3.0	4.4
Alcohol use	8.8	1.6	7.8
Drug use	2.0	1.9	5.6
Domestic violence	0.0	0.0	0.4
Other	2.5	6.1	6.6
Don't know	1.0	0.2	1.8
Number of respondents	511	428	503
Video or TV Presentation			
Antenatal care	26.5	7.1	*
Postpartum care	0.0	1.8	*
HIV/AIDS	0.0	0.0	*
STDs	0.5	0.0	*
Pregnancy prevention	11.6	5.4	*
Child care	4.2	4.5	*
Nutrition of women	26.5	0.0	*
Formula feeding	0.0	0.0	*
Exclusive breastfeeding	92.1	90.2	*
Maternity care oriented to family participation	9.5	15.2	*
Rooming-in option	3.7	3.6	*
Preparation for childbirth	34.4	19.6	*
Partner/family participation in childbirth	33.9	3.6	*
Alcohol use	0.0	0.0	*
Drug use	0.0	0.0	*
Domestic violence	0.0	0.0	*
Other	1.6	2.7	*
Don't know	0.0	0.0	*
Number of respondents	189	112	2

* Estimates based on less than 25 cases are omitted

Table 9.3 Other information clients want or wished they had been given today

SUBJECT	ANTENATAL (%)	POSTPARTUM (%)	ABORTION (%)
Antenatal care	4.1	0.2	0.0
Postpartum care	9.4	6.5	0.0
HIV/AIDS	0.4	0.4	1.6
STDs	0.9	0.7	5.0
Pregnancy prevention	6.4	11.4	17.2
Child care	19.1	27.1	0.0
Nutrition of women	3.4	4.5	0.4
Formula feeding	0.2	0.4	0.0
Exclusive breastfeeding	4.1	7.8	0.9
Maternity care oriented to family participation	2.3	0.0	0.0
Rooming-in option	3.6	0.2	0.2
Preparation for childbirth	31.9	0.0	0.2
Partner/family participation in childbirth	5.3	0.9	0.2
Alcohol use	0.0	0.2	0.0
Drug use	0.0	0.0	0.2
Domestic violence	0.0	0.2	0.4
Other	6.4	15.9	17.9
Nothing/Don't know	39.2	42.8	54.2
Number of respondents	533	446	559

Table 9.4 Self-reported best ways for clients to receive information

CHANNEL	ANTENATAL (%)	POSTPARTUM (%)	ABORTION (%)
During a consultation with medical staff	88.4	87.9	92.3
Pamphlet or brochure	38.8	25.6	22.9
TV or Video talk	36.0	20.4	14.1
Group talk at facility	27.0	24.0	15.0
Some other way	1.9	0.0	0.4
Don't know	1.9	1.8	0.0
Number of respondents	533	446	559

We see from the data displayed in Table 9.1 that, almost all clients report seeing a poster or information sheet in the facility, and more than three-quarters of antenatal and abortion clients and 80% of postpartum clients report being given reading material to take home with them. This is a very large increase from baseline, when only 75% of antenatal and abortion clients and only 34% of postpartum women reported receiving such material. Nearly 70% of providers reported supplying women with reading material.

As the data displayed in Table 9.1 show, almost 40% of postpartum clients, 32% of antenatal clients, and almost 50% of abortion clients reported attending a group talk. Many antenatal and postpartum clients reported seeing a TV or video presentation at the facility (36% and 25% respectively).

Table 9.2 displays the data showing which subjects clients reported receiving information on among the different information channels employed. As we see from the data displayed in Table 9.3, antenatal and postpartum women also desire more information about childcare, and for antenatal clients want more information about childbirth preparation. Almost 20% of abortion clients want more information about pregnancy prevention. And, in Table 9.4, we see that most

clients think that the best way to receive information is through a consultation with their health care provider.

Provider Reports of Topics Discussed with Clients

We asked providers whether they had discussed certain topics with their clients on the day of the interview. About 38% of providers report that they discussed 'family-centered maternity care' with clients on the day of interview (Table 9.5), up from only 10% at baseline. Almost half of all providers reported discussing smoking or alcohol use with clients, while only 4% said they had discussed domestic violence with a client that day.

Nutrition and breastfeeding were topics frequently discussed by providers (67% and 65%), while care of the newborn was discussed by over 40% of the providers (Table 9.5). (Of course, providers of abortion services would not be expected to discuss these topics with their own clients, but they are included in the denominator.)

Table 9.5 Provider reports of information discussed with clients (providers of all types of services combined)

TOPIC	DISCUSSED WITH CLIENTS TODAY (%)
Family-centered maternity care (N=503)	38.1
Nutrition (N=502)	67.3
Breastfeeding (N=502)	64.9
STDs or HIV/AIDS (N=498)	43.6
Smoking or use of alcohol (N=501)	55.3
Care of the newborn (N=502)	42.8
Domestic violence (N=502)	4.2

Client Reports of Information Received about Family-Centered Maternity Care

Prior to the start of the project interventions, we also wanted to discover what information women said they received about topics related to family-centered maternity care (FCMC). While women would not necessarily recognize this term – 'family-centered maternity care' – they could report whether they had discussed certain components of family-centered care with their providers. This follow-up information displayed in Table 9.6 provides us with some proxy information to compare with our baseline information.

Table 9.6 Reports on information about family-centered maternity care

INFORMATION RECEIVED	ANTENATAL CLIENTS (%)	POSTPARTUM CLIENTS (%)
During antenatal visits, discussed preparations for delivery	N/A	74.3
Partner/family member participated in these discussions	N/A	25.7
Staff discussed partner/family participation during childbirth	70.4	N/A
Staff discussed 'rooming-in' option	66.0	N/A
Received any information about 'maternity care oriented to family participation' option for the birthing process	N/A	81.4
• Of those (N=355), selected family-centered maternity care option	N/A	42.0
Number of respondents*	533	436

* Excludes 10 postpartum clients who did not receive antenatal care

Three-quarters of postpartum women reported that they discussed preparations for delivery during their antenatal visits, but of those, only about one-quarter reported that a partner or other family member participated in those discussions (Table 9.6). This still compares well – at baseline, only 55% of these women reported discussion preparations for delivery, and of that smaller number, 27% reported that their partner or family member participated in those discussions.

Of antenatal clients, 70% reported that their provider had discussed family participation during childbirth (Table 5.12), up from 21% at baseline, and 66% reported discussing the option for 'rooming-in' with their newborn, up from only 15% at baseline. Eighty-one percent of the postpartum women reported receiving information about the FCMC option before delivery (up from 25%) and 47% of those say they chose that option. Almost all postpartum women who selected the FCMC option say they would choose it again (95% of respondents).

10. GENERAL SATISFACTION

Finally, we asked some questions of both clients and providers about how they would rate the services in their facility. Clients are often reluctant to say anything critical about the staff or the facility, and more likely to report that they are satisfied with services, when interviewed at the facility. We have therefore included some items in this section of the questionnaire to obtain a more objective assessment, such as 'Would you recommend a friend to come to this facility?' Results from these client interviews should be interpreted cautiously, and with the recognition that they may suggest a more positive assessment than is real.

Clients' Rating of Service Received

We asked clients first to rank the facilities where they were interviewed on 4 dimensions – hygiene, comfort, competence of health professionals, and courtesy of health professionals.

Overall rankings for each service were quite high, but mean scores mask a fair amount of variation among respondents (Table 10.1). In general, rankings for provider courtesy are quite high, while women rank facilities lower on comfort. Ratings for 'competence of providers' are highest, and improved considerably from baseline, when all types of clients gave 'competence ratings of 1.3 to 1.8.

Table 10.1 Mean rating given by clients for attributes of each service (1='good' 3='poor')

	ATTRIBUTES OF SERVICES RECEIVED			
TYPE OF CLIENT	HYGIENE	COMFORT	COMPETENCE OF PROVIDERS	COURTESY
Antenatal	1.26	1.58	1.08	1.20
Postpartum	1.42	1.66	1.04	1.08
Abortion	1.32	1.67	1.06	1.14

The distribution of rankings (all clients combined) for each city separately and in total is shown in Table 10.2 below.

Table 10.2 Client rankings given to facilities (all clients combined) by city

	CITY			
ATTRIBUTE AND RANKING	V. NOVGOROD (%)	PERM (%)	BEREZNIKI (%)	TOTAL (%)
Hygiene				
Good	63.6	74.2	65.1	69.3
Fair	33.0	22.8	32.6	27.8
Poor	1.4	2.8	2.1	2.3
Don't know	1.9	0.1	0.3	0.7
Total	100	100	100	100
Comfort				
Good	35.6	50.1	42.2	44.4
Fair	49.5	43.9	50.7	46.9
Poor	13.9	5.8	6.7	8.2
Don't know	1.0	0.3	0.3	0.5
Total	100	100	100	100
Competence of health professionals				
Good	79.7	89.3	96.5	88.3
Fair	11.5	2.8	2.9	5.2
Poor	4.1	0.4	0.0	0.3
Don't know	4.8	7.4	0.6	6.2
Total	100	100	100	100
Courtesy of health professionals				
Good	68.4	93.6	93.3	86.7
Fair	27.3	6.0	5.3	11.6
Poor	3.6	0.0	0.9	1.2
Don't know	0.7	0.4	0.6	0.5
Total	100	100	100	100
Number of respondents	418	779	341	1538

When we combine all three types of clients, we can compare the proportion who give rankings of 'good' to their facility on the four criteria – hygiene, comfort, competence of health professionals and courtesy of health professionals. We can see in Table 10.2 and Figure 10.1 on the following page that client rankings of hygiene improved in both Perm and Berezniki over the baseline rankings (from 66% to 74% in Perm and from 58% to 65% in Berezniki), while declining in V. Novgorod from 70% to 64%).

Clients in V. Novgorod have the least favorable impression of the comfort provided by their facilities. Less than half of all clients consider the comfort of their facilities to be "good", and in Novgorod, this falls to only 35% of all clients. Berezniki shows the greatest improvement from baseline – 21% ranked comfort 'good' at baseline, doubling to more than 40% now.

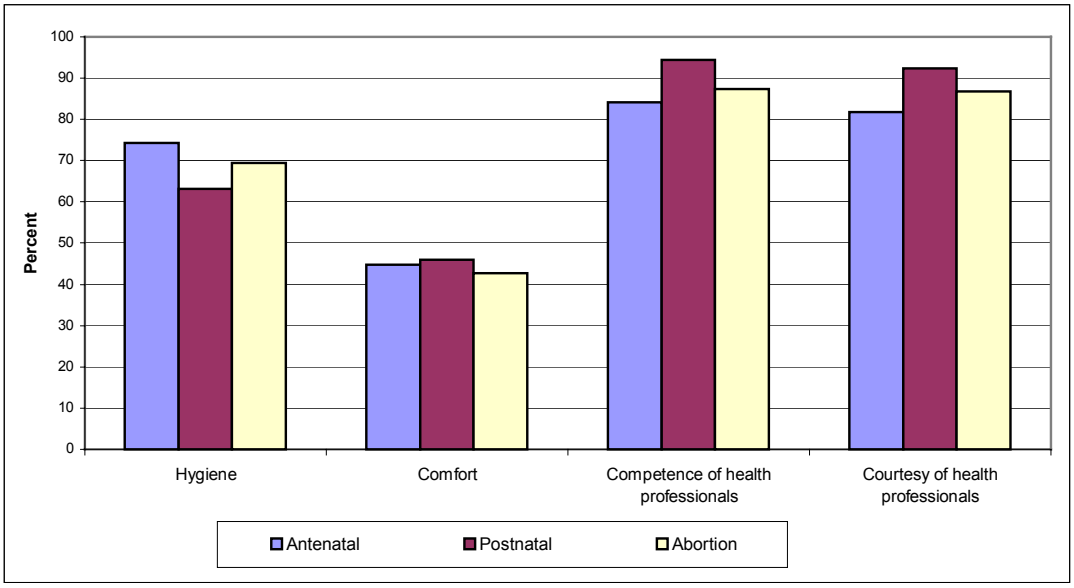
In all, clients are mostly satisfied with the competence and courtesy of their health professionals (almost 90% of clients rate their facility as "good" on these criteria), but again, V. Novgorod fares least well among the cities, especially for courtesy of providers.

Analysis of satisfaction by client type yields reveals trends similar to that of analysis by city (Table 10.3).

Table 10.3 Client rankings given to facilities for services received

	Client Type		
Attribute and Ranking	Antenatal (%)	Postnatal (%)	Abortion (%)
Hygiene			
Good	74.3	63.2	69.4
Fair	24.8	30.9	28.1
Poor	0.4	5.2	1.8
Don't know	0.6	0.7	0.7
Comfort			
Good	44.8	46.0	42.8
Fair	51.2	41.9	46.9
Poor	3.4	11.7	10.0
Don't know	0.6	0.4	0.4
Competence of health professionals			
Good	84.2	94.4	87.3
Fair	6.4	3.6	5.4
Poor	0.6	0.2	0.0
Don't know	8.8	1.8	7.3
Courtesy of health professionals			
Good	81.8	92.4	86.8
Fair	15.4	7.2	11.6
Poor	2.1	0.2	1.1
Don't know	0.8	0.2	0.5
Number of respondents	533	446	559

Figure 10.1 Proportion of clients giving a ranking of "Good" to their facility on four criteria, by client type



Satisfaction with maternity services

Postpartum women who were interviewed before discharge from the maternity were asked to report on several indicators of their satisfaction with the services they had received. The distribution of their responses is shown in Table 10.4. Women report high levels of satisfaction with the facility, overall, and most (almost 75% of women) were satisfied with the degree of privacy in their consultations with medical staff. This represents a big improvement in Berezniki and a small decline in V. Novgorod. In all three cities, about four women in every five said they would recommend a friend to deliver in the same facility.

Table 10.4 Responses by postpartum clients to questions about satisfaction with maternity services, by city

	CITY			
CRITERIA	V. NOVGOROD (%)	PERM (%)	BEREZNIKI (%)	TOTAL (%)
Satisfied overall	90.6	96.2	98.9	95.3
Enough privacy in consultations with doctor or midwife	61.5	76.2	72.3	71.5
Medical staff permitted questions*	92.0	98.3	100.0	97.2
Recommend a friend to deliver here	83.8	82.6	78.7	82.1
Number of respondents	117	235	94	446

* Of those who had questions they wanted to ask

Satisfaction with antenatal services

Antenatal clients were asked a series of similar questions. As with postpartum women, most antenatal clients (more than 95%) were satisfied with overall services (Table 10.5), and most (more than 70%) felt that they had enough privacy during consultations with medical staff. Only about 70% of women in Veliky Novgorod said they would recommend this facility to a friend, but almost 90% in Perm and 80% in Berezniki said they would recommend the facility to a friend. This is a decline for V. Novgorod (from 98% to 71%) and a big improvement for Perm (63% to 88%) and Berezniki (58% to 79%).

Table 10.5 Responses by antenatal clients to questions about satisfaction with antenatal care, by city

			CITY	
CRITERIA	V. NOVGOROD (%)	PERM (%)	BEREZNIKI(%)	TOTAL (%)
Satisfied overall	92.3	96.6	98.4	95.9
Enough privacy in consultations with doctor or midwife	79.0	67.8	68.3	70.9
Medical staff permitted questions*	91.9	94.6	100.0	95.4
Recommend this facility to a friend	70.6	88.0	78.9	81.2
Number of respondents	143	267	123	533

* Of those who had questions they wanted to ask

Only 45% of antenatal clients rated the facility's level of comfort as 'good' (Table 10.3).

Satisfaction with abortion services

Privacy was more of a problem for abortion clients: less than half of these women in Veliky Novgorod and Berezniki, and only 75% of women in Perm reported that they had enough privacy during medical consultations (55% overall). But less than 10% of women who said they had

questions reported that medical staff did not permit them to ask the questions. (This varied widely by city, as shown in Table 10.6.) Almost all women in Perm said they would recommend the facility to a friend who needed an abortion (92%). In Veliky Novgorod, this fell to only about 78% of women who would recommend a friend to come to that facility. In Berezniki about three quarters (73%) of abortion clients would recommend the facility (Table 10.6).

Table 10.6 Responses by abortion clients to questions about satisfaction with abortion services, by city

CRITERIA	CITY			TOTAL (%)
	V. NOVGOROD (%)	PERM (%)	BEREZNIKI (%)	
Satisfied overall	91.8	97.8	99.2	96.4
Enough privacy in consultations with doctor or midwife	38.6	75.5	32.3	55.5
Medical staff permitted questions*	76.1	97.1	96.1	92.5
Recommend this facility to a friend	78.5	92.1	73.4	84.1
Number of respondents	158	277	124	559

* Of those who had questions they wanted to ask

Like the other clients, abortion clients were most dissatisfied, relative to other client types, with the level of comfort in the facility where the abortion was performed (only 43% rated their facility as "good"), but more than 70% of these women ranked hygiene as optimal ("good") (Table 10.3). Almost 10% of abortion clients said they could not judge the competence of health professionals at the facility. In general abortion clients rated their health providers highly in terms of competence and courtesy (Table 10.3). Only about 13% of abortion clients rated their providers less than "good" on 'courtesy'.

Provider and client attitudes toward men receiving services

One way to improve women's reproductive health is to involve their partners in reproductive health care, and to improve the preventive behaviors that lead to improved health of men. We asked abortion and antenatal clients, as well as health providers, if they thought that men should have access to reproductive health services at the facility. We can see from the data displayed in Table 10.7 that most abortion clients (78%) in all three cities are in favor of providing such services to men but that abortion clients in Veliky Novgorod are in less agreement relative to those in Perm and Berezniki. Most antenatal clients (81%) were also in favor of providing male reproductive health services at women's consultation centers, but only 70% of antenatal clients in Veliky Novgorod approved. Providers attitudes were slightly less favorable (only about 65% of providers approved, up from 60%), but varied widely between cities. Only 32% of providers in Veliky Novgorod were in favor of providing services to men at their facility, but this rose to almost 80% of providers in Perm and nearly 100% of providers in Berezniki.

Table 10.7 Attitudes of clients and providers to extending reproductive health services to men

MEN SHOULD HAVE ACCESS TO SERVICES AT THIS FACILITY	CITY			TOTAL (N)
	V. NOVGOROD (%)	PERM (%)	BEREZNIKI (%)	
Antenatal clients	70.6	80.9	94.3	81.2 (533)
Abortion clients	60.8	81.9	89.5	77.6 (559)
Providers	32.4	79.3	100.0	65.0 (500)

Providers' Rating of Services

Finally, we asked medical staff to rank their own facilities on three of the same criteria which the clients had ranked. We did not ask providers to rate competence and courtesy of professionals, but instead asked them to rank their facility for the privacy offered to clients. Their responses are displayed in Table10.8.

Table 10.8 Provider rakings given to their own facilities, by city

ATTRIBUTE AND RANKING	CITY			TOTAL (%)
	V. NOVGOROD (%)	PERM (%)	BEREZNIKI (%)	
Hygiene				
Good	61.4	58.6	45.6	57.9
Fair	33.2	35.1	50.0	36.4
Poor	5.4	6.0	2.9	5.4
Don't know	0.0	0.4	1.5	0.4
Total	100	100	100	100
Comfort				
Good	24.5	31.1	29.4	28.4
Fair	52.2	51.8	45.6	51.1
Poor	22.8	16.7	25.0	20.1
Don't know	0.5	0.4	0.0	0.4
Total	100	100	100	100
Privacy				
Good	22.3	30.0	32.4	27.5
Fair	40.2	46.4	41.2	43.4
Poor	35.9	23.2	26.5	28.3
Don't know	1.6	0.4	0.0	0.8
Total	100	100	100	100
Number of respondents	184	251	68	503

Broadly, providers in these facilities gave less positive reports than clients in their assessments of facility hygiene, comfort and privacy than their clients were. One-fifth of providers rated the comfort in their facilities "poor", and less than 30% rated their facility as "good" in this respect, unchanged from baseline. Only about 60% of medical staff rated their facility's hygiene as "good", and almost 5% rated hygiene as "poor", but this assessment is more favorable than at baseline. Just over a quarter (28%) of caregivers said that the privacy afforded to patients at their facility was poor. Additionally, just over a quarter of these medical professionals thought that privacy for clients was optimal (28%), again virtually unchanged from baseline.

11. CONCLUSIONS

This survey is one component of the WIN Project evaluation, and has provided data on key indicators of project performance after two years of activities, to compare with baseline measures.

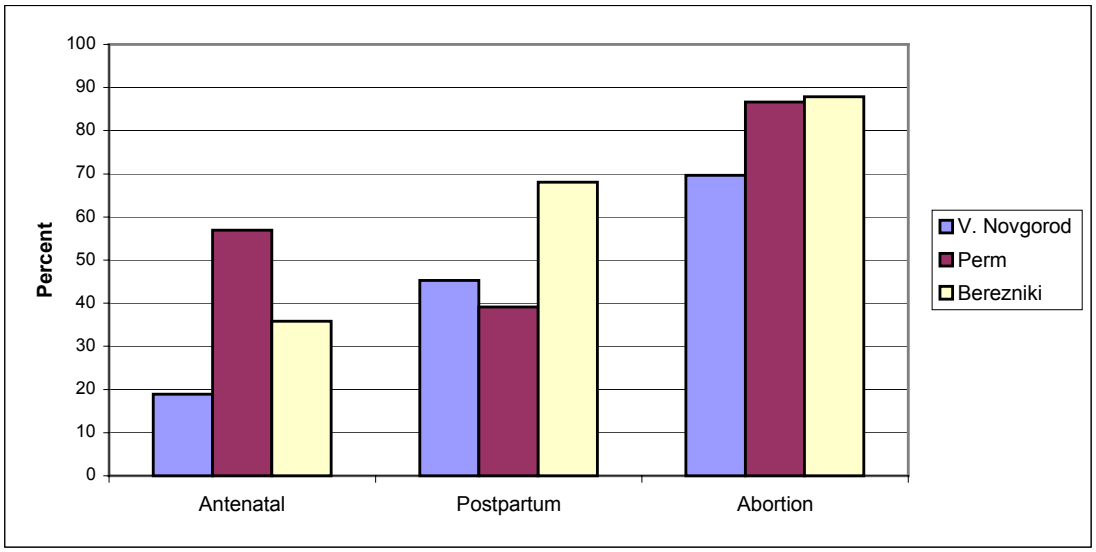
One of the main findings is that prevalence of abortion and repeated abortion by all types of clients remains virtually unchanged from baseline. Of women who had had more than one pregnancy (including the current one) more than 70% of antenatal and postpartum and 80% of abortion clients had least one previous abortion. Of those repeat abortion clients, 17% had terminated a pregnancy by abortion within the previous calendar year.

Another conclusion of this follow-up study is that contraceptive counseling in all women's health services has improved markedly, more than doubling for all three types of clients from pre-intervention practice. Forty-two percent of antenatal clients reported discussing contraception with medical staff at the facility. Eighty-two percent of post-abortion and 47% of postpartum clients received family planning counseling prior to discharge.

From the provider reports, fully 85% of antenatal caregivers, 67% of delivery caregivers and 95% of abortion providers reported that they discuss contraception with their clients.

However, based on the reports of clients shown in Figure 11.1, there is still room for providers to improve their coverage of clients with an offer of counseling about pregnancy prevention. Antenatal care providers, especially, could do much better in this regard, but those in Perm are reaching a higher proportion of antenatal clients than in the other two cities. Given the preference for smaller sized families, it is clear that all women seeking care in these facilities would benefit from discussion of contraceptive choices with her health care provider.

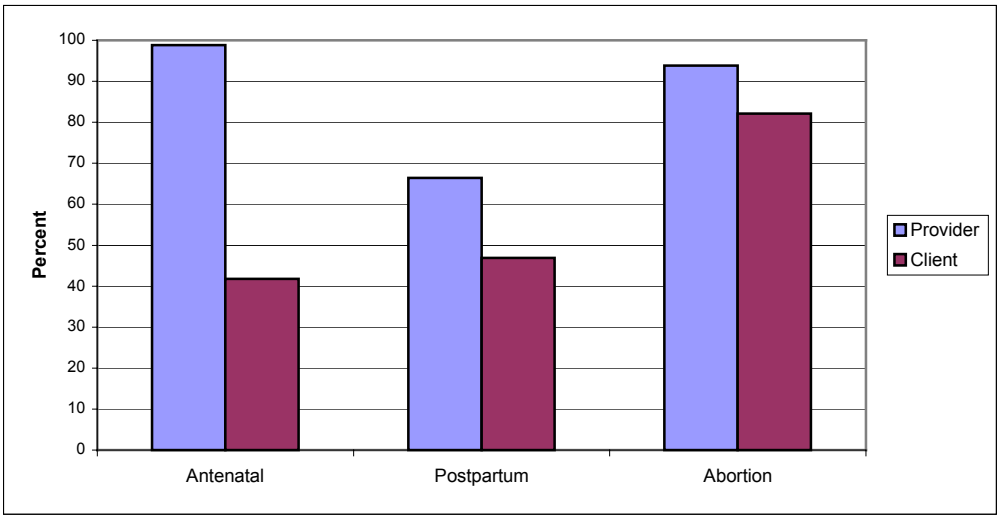
Figure 11.1 Percent of clients who discussed contraception with medical staff, by city and client type



As these data about contraceptive counseling suggest, information obtained from providers was sometimes inconsistent with client reports, and this discrepancy is shown when we combine provider and client reports in Figure 11.2. The degree of inconsistency between what providers

say they do routinely, and what clients report they receive has, however, also lessened markedly from the baseline situation.

Figure 11.2 Provider and client reports: discussed contraception



Another conclusion we can draw is that many more women (9 out of 10) are exclusively breastfeeding throughout their hospital stay. And, now more providers actually counsel women to breastfeed exclusively for the first 6 months. The message has also taken effect, and maternity hospitals have altered their practices to support women who want to breastfeed exclusively. Postpartum women were asked "What does the term 'exclusive breastfeeding' mean to you?" The 'correct' answer is breast milk and nothing else, except vitamins, minerals or medicine, and 88% of postpartum women could define this correctly (Figure 11.3). Providers were asked "When you talk to your clients about breastfeeding, what do you recommend they feed their baby in the first 6 months?" We see in the figure that 88% of delivery care and neonatal caregivers say they recommend their clients to breastfeed on demand, and 62% of delivery caregivers and 78% of neonatologists tell mothers to breastfeed exclusively for a full six months (e.g. do not recommend supplementing with anything else until 6 months of age). Furthermore, few postpartum women (less than 2%) said they were advised to supplement their breast milk with water, down from 46% for whom this was recommended at baseline.

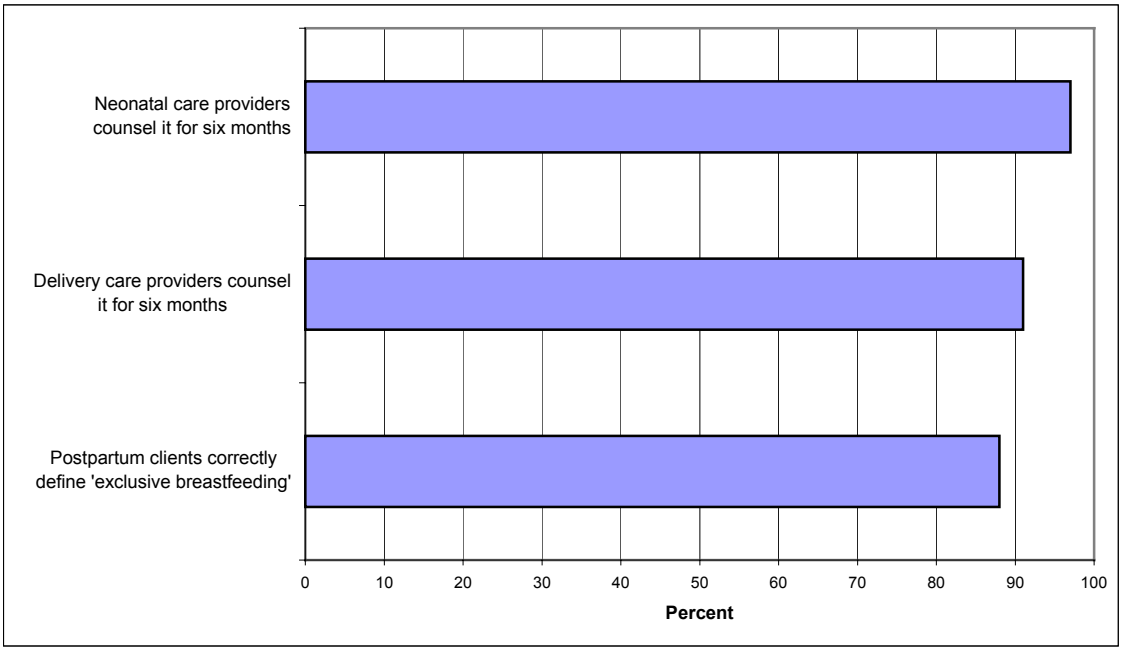
Almost all women start out to breastfeed their babies. Ninety-eight percent of postpartum women reported that they were currently breastfeeding. Of those, only 10% said their baby was given something to drink from a bottle during the hospital stay, and 84% said they were feeding 'on demand'. This suggests that change is occurring in routine hospital practice regarding breastfeeding, and that these changes are in line with WIN's training in breastfeeding counseling and support. A full 88% of postpartum report exclusively breastfeeding throughout their hospital stay, more than tripling from baseline, when only 25% of women were doing so.

Eighty-two percent of postpartum women said they had their baby with them in their room day and night ('rooming in'), and only 9% of these women reported that their baby was taken to a nursery for the first night.

One of the characteristics of 'family-centered maternity care' is closer contact between mother and baby and more involvement by other family members in antenatal preparations for the birth,

as well as support during labor and in the postpartum period. At baseline, we found that in participating facilities, 96% of women said they had no close person supporting them at the birth. This has improved markedly, now only 48% reported no close person supporting them, and only 32% of all postpartum women said they did not want a close person with them if they had another birth. This describes a marked change in practice at facilities, and also a marked change in women's attitudes – at baseline nearly 60% of women said they did not want someone to support them during labor and delivery.

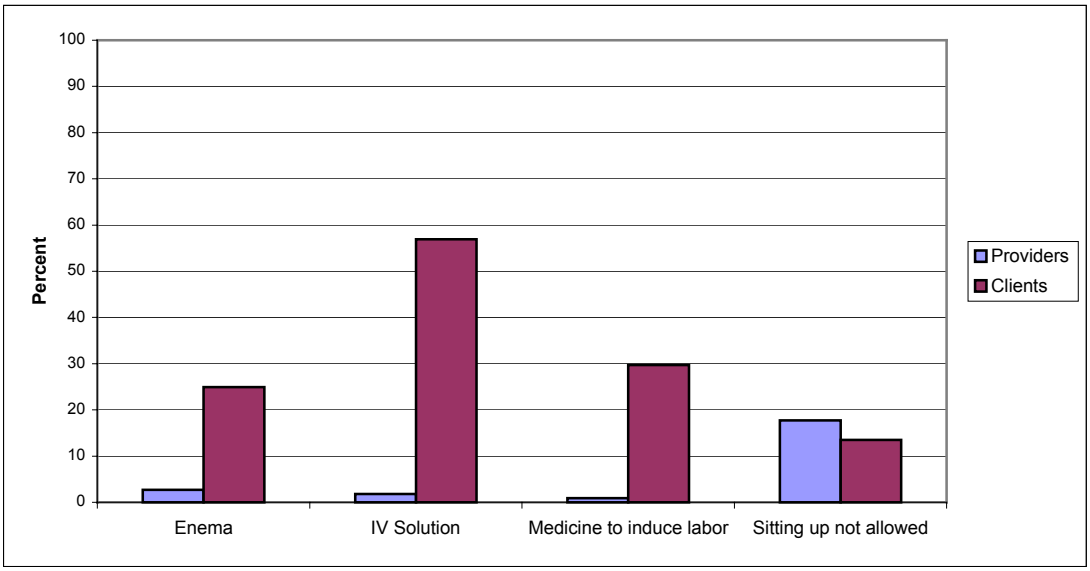
Figure 11.3 Exclusive breastfeeding: client knowledge and provider counseling



Other discrepancies highlight issues of quality of care provided to women: 87% of abortion providers said they explain the procedure to clients prior to performing an abortion, and 62% of clients reported receiving such information, up from slightly more than half (56%).

The data displayed in Figure 11.4 shows results of reports from women just recently delivered in participating facilities about some of the changes made that reduce delivery procedures that are not proven to be beneficial.

Figure 11.4 Reports of delivery care practices by providers and clients



At baseline, 92% of postpartum women reported having an enema, yet now only 25% report having one; 85% of postpartum women reported having an IV solution during labor, but that has dropped to 57% in the follow-up survey. At baseline, almost half of postpartum women (47%) reported that their labor was induced, whereas after two years of training activities, only 30% report that their labor was induced. At baseline, 31% of providers said allowing women to sit up during labor was the usual practice for all women, while at follow-up, 82% said this was allowed, and only 14% of postpartum women report they were not allowed to sit up during their labor, compared with 56% at baseline.

These and other findings suggest that major changes in facility practices, as well as in provider and client knowledge, attitudes and behavior promoted by the WIN Project can be achieved in a very short period of time. These results demonstrate that both providers of women's health care and their clients want to adopt these new practices and behaviors.

Quantitative data obtained using sound methodologies are essential for project evaluation. These data can also be used to attain project objectives by providing a firm basis for policy discussions. Our findings from the second round of facility surveys show that some practices affecting quality of care have changed accordance with WIN training. At the same time, some practices that are not evidence based persist, and there continues to be room for improvement.

These and other findings can be used to continue discussion and action among facility staff and policy-makers, and to encourage staff about the steps that they have already taken.

Key WIN Indicators
Indicators related to abortion

Baseline[13] - 76% of abortion clients, 75% of postpartum women, and 78% of antenatal clients who had more than one pregnancy had had a previous abortion.

2nd round -80% of abortion clients, 72% of postpartum women, and 75% of antenatal clients who had more than one pregnancy had had a previous abortion.

B-18% of repeat abortion clients (gravidity 2 or more) had terminated a pregnancy by abortion within the previous calendar year

2nd-17% of repeat abortion clients (gravidity 2 or more) had terminated a pregnancy by abortion within the previous calendar year

Abortions following a birth:
B – 8.4% abortion clients whose abortion followed within one year of last live birth

2nd – 7.8% abortion clients whose abortion followed within one year of last live birth

B-41% of post-abortion women received or were offered family planning counseling on the day of the abortion at the facility where the abortion took place.

2nd -82% of post-abortion women received or were offered family planning counseling on the day of the abortion at the facility where the abortion took place.

B-More than 75% of abortion clients who know what method they will use name a medical reversible method and more than 90% name a modern method – medical reversible, sterilization or barrier.

2nd -76% of abortion clients who know what method they will use name a medical reversible method and more than 99% name a modern method – medical reversible, sterilization or barrier.

B-48% of these women discussed use of their chosen method with a member of facility medical staff.

2nd -64% of these women discussed use of their chosen method with a member of facility medical staff.

B-Of these latter women, 83% said that the person had clearly explained how the method works, described the possible side effects, and explained what to do in case of problems with the method (an indicator of the quality of counseling provided).

2nd -Of these latter women, 96% said that the person had clearly explained how the method works, described the possible side effects, and explained what to do in case of problems with the method (an indicator of the quality of counseling provided).

[13] David, PH, *Women and Infant Health Project Facility Survey 2000: Report of Main Findings, January 2001*

Indicators related to breastfeeding

B-74 % of antenatal care providers say they discuss exclusive breastfeeding with their clients.

2nd -99 % of antenatal care providers say they discuss exclusive breastfeeding with their clients.

B-47 % say they recommend giving only breast milk and nothing else (except vitamin and mineral supplements or medicine) for the first 6 months.

2nd -94 % say they recommend giving only breast milk and nothing else (except vitamin and mineral supplements or medicine) for the first 6 months.

B-Of those who counsel on breastfeeding, 28% of neonatal caregivers and 27% of delivery caregivers report that they recommend exclusive breastfeeding for the first six months

2nd -Of those who counsel on breastfeeding, 97% of neonatal caregivers and 91% of delivery caregivers report that they recommend exclusive breastfeeding for the first six months

B-56% of antenatal clients can correctly define 'exclusive breastfeeding'

2nd -67 % of antenatal clients can correctly define 'exclusive breastfeeding'

B-49 % of postpartum clients can correctly define 'exclusive breastfeeding'.

2nd -88 % of postpartum clients can correctly define 'exclusive breastfeeding'.

B[14] –25% of postpartum women said their baby was exclusively breastfed, and not given drinks from a bottle during their hospital stay

2nd – 88% of postpartum women said their baby was exclusively breastfed, and not given drinks from a bottle during their hospital stay

Indicators related to family-centered maternity care:

B – 4 % of women had family support during labor/delivery
2nd – 32% of women had family support during labor/delivery

B – 38% of women had their baby with them day and night
2nd – 82% of women had their baby with them day and night

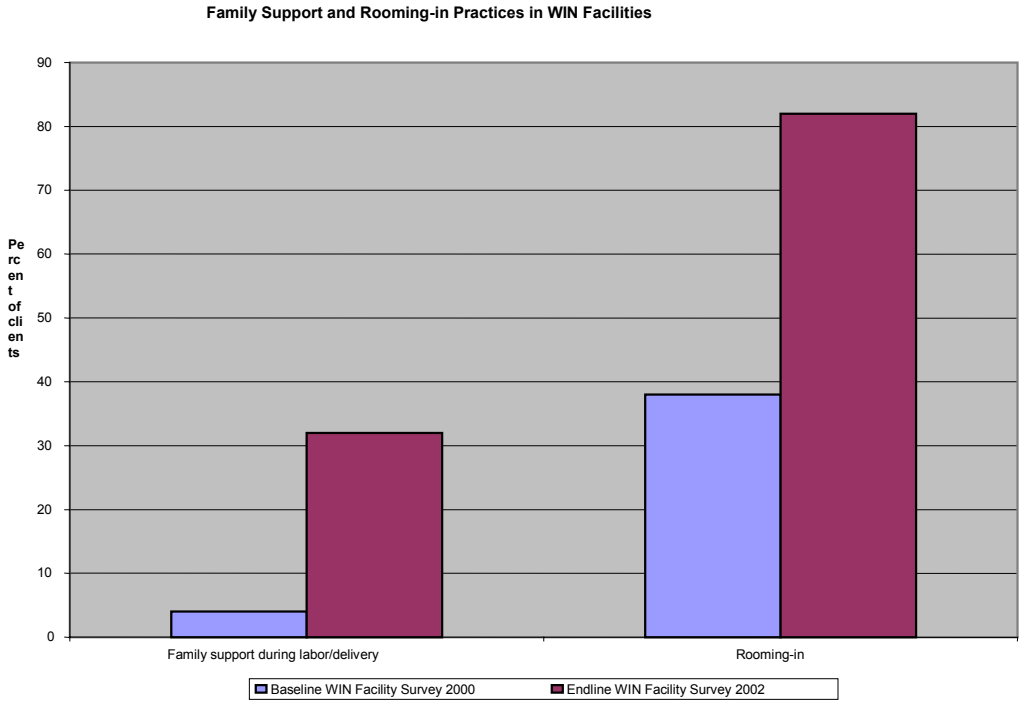
[14] Both 2nd round and baseline for these indicators were re-calculated to include all women interviewed in the denominator, rather than restricting the indicator to the % of currently breastfeeding women whose infants were exclusively breastfed while in hospital (see Table 6.19, p. 53 (2000 survey report) and Table 6.19, p. 28 (2002 survey report).

B – 55.2 % of women report immediate skin-to-skin contact with their newborn
2nd – 89.9% of women report immediate skin-to-skin contact with their newborn

Table 11.1 Practices in maternity reported by clients

	BASELINE	2ND ROUND
Percent who had perineal shave	93.2	42.7
Percent who had enema	92.3	24.9
Percent who had IV solution during labor	85.2	56.9
Percent who had medicine to induce labor	46.9	29.7
Percent who were given medicine for pain relief	62.3	47.6
Restricted in what she could eat	34.4	18.2
Percent whose membranes were artificially ruptured	54.9	47.2
Percent who had an episiotomy	29.3	16.4
Percent who walked during labor	67.3	82.2
Percent not allowed to sit up during labor	56.2	13.5

Figure 11.5 Percent of women with support and rooming-in



Indicators related to contraceptive use

B-51% of postpartum clients know what contraceptive method they will use.

2nd-62% of postpartum clients know what contraceptive method they will use.

B-93 % of postpartum clients report they will use a modern method of birth control postpartum (medical, reversible or sterilization, barrier) and 72 % will use a medical method.

2nd-74 % of postpartum clients report they will use a modern method of birth control postpartum (medical, reversible or sterilization, barrier) and 50 % will use a medical method.

Note: an additional 25% of these postpartum women will use LAM – and see next indicator – which means that for postpartum women, choice of LAM appears to have reduced use of medical methods, which fell from 72% at baseline to 50% at the second round. Women who chose traditional methods fell from 4.2 at baseline to 0.4% at the second round.

B -12% of all postpartum women thought breastfeeding could be used as a contraceptive.

2nd- 46% of women thought breastfeeding could be used as a contraceptive.

B-79% of contraceptive users (all clients combined) report using modern methods (medical or barrier methods) prior to this pregnancy.

2nd- 80% of contraceptive users (all clients combined) report using modern methods (medical or barrier methods) prior to this pregnancy.

B-32.5% of contraceptive users (all clients combined) were using medical methods (oral, IUD, injections, implants, post-coital pill) prior to the current pregnancy.

2nd-28% of contraceptive users (all clients combined) were using medical methods (oral, IUD, injections, implants, post-coital pill) prior to their current pregnancy.

Contraceptive counseling:

Table 11.2 Percent of clients who discussed contraception with medical staff

	ANTENATAL	POSTPARTUM	ABORTION
Baseline	23	19	41
2nd round	41.8	46.9	82.1

Indicators of Information, Education and Communication

Table 11.3 Percent of clients who were given or took a brochure or educational materials to read away from clinic

	ANTENATAL	POSTPARTUM	ABORTION
Baseline	25.3	33.6	25.2
2nd round	76.5	80.5	76.4

B – 30.2 % of providers gave women educational material to read

2nd – 68.4% of providers gave women educational material to read

Table 11.4 Reports from women in facilities about materials and information received

INDICATOR	PERCENT OF WOMEN REPORTING 'YES'	
	BASELINE	2ND ROUND
Were given or took a brochure or educational material from clinic		
• antenatal clients	25.3 (491)	76.5 (533)
• postpartum clients	33.6 (324)	80.5 (446)
• abortion clients	25.2 (489)	76.4 (559)
Subject of brochure/educational material was: (of those who received)		
Exclusive breastfeeding		
• antenatal clients	6.3	78.0
• postpartum clients	17.0	90.0
Pregnancy prevention		
• antenatal clients	13.4	56.0
• postpartum clients	8.3	51.0
• abortion clients	23.5	98.0
HIV/STDs		
• antenatal clients	14.9	21.0
• postpartum clients	3.4	12.5
• abortion clients	3.1	22.8
Child care		
• antenatal clients	5.7	10.8
• postpartum clients	4.3	36.8
Formula feeding		
• postpartum clients	13.0	0.6
N of antenatal clients	124	408
N of postpartum clients	109	359
N of abortion clients	123	427

B – 4.3% of antenatal clients, 0.0% of PP, and 0.4% of abortion clients saw a video or TV presentation at facility

2nd – 35.5% of antenatal, 25.1% of postpartum, and 0.4% of abortion clients saw a video or TV presentation at facility

B – 18.9% of antenatal clients, 11.4% of postpartum clients, and 27.4% of abortion clients attended a group talk that day

2nd – 31.7% of antenatal clients, 38.8% of postpartum clients, and 47.9% of abortion clients attended a group talk today (85.8% of abortion clients attended a group talk on pregnancy prevention)

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